RESILIENCE IN YOUTH RECENTLY DIAGNOSED WITH PSYCHOSIS: A QUALITATIVE INQUIRY

by

SHALINI LAL

B.Sc., McGill University, 1996
M.Sc., McGill University, 2002

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY in THE FACULTY OF GRADUATE STUDIES (Rehabilitation Sciences)

THE UNIVERSITY OF BRITISH COLUMBIA (Vancouver)

October 2012

© Shalini Lal, 2012
ABSTRACT

BACKGROUND: Psychotic disorders are among the most disabling health issues affecting young people today. Clinical and psychosocial interventions are considered to have the most potential for preventing the disabling consequences of this illness during the first two to five years following the onset of a psychotic disorder. The development of interventions for this stage of the illness is partially dependent upon understanding how young people build resilience within the context of their daily lives. Yet, little research has been conducted on resilience particularly based on the narrative accounts of youth themselves.

OBJECTIVE: To better understand how youth recently diagnosed with a psychotic disorder restore, sustain, and enhance their resilience (capacity to cope with adversity), and how aspects of the environment, and the activities they engage in, support and/or hinder this process.

METHODS: Using a qualitative approach, combining grounded theory, narrative, and arts-based methods at different stages of the research process, 17 young people, between the ages of 18 to 24, diagnosed with psychosis within the past three years, were recruited from two Canadian mental health care settings: a specialized early psychosis intervention program and a general psychiatric service for street youth. Over the duration of 1 year, 36 individual interviews and three focus group meetings were conducted, supplemented by participants’ creation of biographical, literary and visual accounts. Prolonged engagement, methodological crystallization, transparency, and reflexivity enhance the rigour and trustworthiness of the findings.

RESULTS: Data analysis led to the explication of normalizing-identity work, a psychosocial process that involves navigation towards and engagement in narrative practices and highly valued activities to enhance one’s normal sense of self and identity, in conjunction with the social, structural, and technological environment’s capacity to facilitate access to this process in meaningful ways.

CONCLUSION: The findings illustrate that a key pathway through which participants sustain, restore, and enhance their resilience is engagement in identity work. The findings contribute to theoretical and empirical knowledge that further understanding of the phenomena of resilience, well-being, and psychosocial recovery in relation to youth recently diagnosed with psychosis, as well as offer practical implications for the specialized field of early psychosis intervention.
This research study received ethics approval from the University of British Columbia’s Behavioural Research Ethics Board (Reference number H10-01903) on September 21, 2010. Institutional approval was also granted from the Providence Health Care Research Institute and the Vancouver Coastal Health Research Institute. Portions of chapters 1, 2, and 4 have been published in three distinct peer-reviewed papers. I have obtained copyright permission to use and/or adapt the text from these three works for the dissertation. The references for these three papers are:

- Lal, S., Suto, M., & Ungar, M. (2012). Examining the potential for combining the methods of grounded theory and narrative inquiry: A comparative analysis. *The Qualitative Report, 17* (41), 1-22. I wrote the first draft of this manuscript; fellow authors M. Suto and M. Ungar provided contributions to the revised manuscript.

- Lal, S., Jarus, T., & Suto, M. (2012). A scoping review of the photovoice method: Implications for occupational therapy research. *Canadian Journal of Occupational Therapy, 79*, 181-190. I conducted the data collection and analysis, and wrote the first draft; fellow authors T. Jarus and M. Suto provided contributions to the revised manuscript.

- Lal, S. (2010). Prescribing recovery as the new mantra for mental health: Does one prescription serve all? *Canadian Journal of Occupational Therapy, 77*, 82-89. doi: 10.2182/cjot.2010.77.2.4 I wrote this manuscript in its entirety. The manuscript was developed based on a paper written within the context of a graduate level course I completed.

It is anticipated that portions of chapters 1, 2, 3 and 4 will be developed into three manuscripts. In consultation with doctoral supervisors (Drs. Melinda Suto and James Frankish at the University of British Columbia) and doctoral committee members (Drs. Carl Leggo, University of British Columbia; Michael Ungar, Dalhousie University; and Ashok Malla, McGill University), I conceptualized and developed the research protocol, collected and analysed the data, and wrote this thesis manuscript in its entirety.
TABLE OF CONTENTS

ABSTRACT ............................................................................................................................................. ii
PREFACE.................................................................................................................................................. iii
TABLE OF CONTENTS ............................................................................................................................... iv
LIST OF TABLES ....................................................................................................................................... vii
LIST OF FIGURES .................................................................................................................................... viii
LIST OF ABBREVIATIONS ......................................................................................................................... ix
ACKNOWLEDGEMENTS .......................................................................................................................... x
DEDICATION ............................................................................................................................................. xii
PROLOGUE ............................................................................................................................................... xiii

CHAPTER 1: INTRODUCTION AND LITERATURE REVIEW ..................................................................... 1
  Synopsis..................................................................................................................................................... 1
  Psychotic Disorders: Prevalence, Symptoms, Morbidity and Mortality .............................................. 2
  The Promise of Early Intervention ......................................................................................................... 3
  Treatment Challenges and Gaps in the Research Literature ............................................................... 5
    Limited attention to the psychosocial issues of recovery ................................................................. 7
    Limited attention to narrative perspectives ....................................................................................... 8
  Shifting Focus towards Narrative, Resilience Oriented Perspectives ............................................. 9
  Conceptualizing the Bridge between Resilience and Recovery ...................................................... 11
  A Conceptual and Historical Review of the Construct of Resilience ........................................... 14
    Research issues, limitations, and gaps in the literature ................................................................. 19
  Research Questions and Objectives .................................................................................................... 22
    Research questions ............................................................................................................................. 23
    Primary objectives .............................................................................................................................. 23
    Secondary objectives .......................................................................................................................... 23

CHAPTER 2: METHODOLOGY .................................................................................................................. 24
  Synopsis..................................................................................................................................................... 24
  Section 1: Positioning the Research/er on a Paradigmatic Continuum ......................................... 25
    An overview of constructivism ........................................................................................................... 26
    Enacting a constructivist stance and navigating the tensions therein ........................................ 27
An overview of symbolic interactionism..........................................................30

Section 2: Making the Case for a Combined Methodological Framework ..........31
An emerging trend.....................................................................................32
Cautionary considerations.........................................................................33
Comparing grounded theory and narrative inquiry on 12 methodological features ......35

Section 3: Setting, Sampling, and Recruitment ........................................46
Research setting ..........................................................................................47
Sampling ....................................................................................................48
Recruitment ...............................................................................................49
Characteristics of the sample .....................................................................50

Section 4: Methods....................................................................................52
Data collection: Overview of the process and description of the methods ........52
Data management, analytical framework, and representation of findings ..........61

Section 5: Quality Appraisal ......................................................................64
Navigating the cornucopia of quality appraisal criteria ..............................65
Moving towards universal criteria..............................................................66
Summary..................................................................................................69

CHAPTER 3: FINDINGS ...........................................................................70

Synopsis......................................................................................................70

Section 1: Well-being and the Subtext of Normality ................................71
Synopsis......................................................................................................71
Well-being: Multidimensional, action oriented, and directed towards normality ....71
Normal: Meanings conveyed by young people experiencing early psychosis ....74
Normal: Experiences of abnormality/difference and their influence on identity ....77
A note on the self, identity, and identity work...........................................78
Summary..................................................................................................79

Section 2: Normalizing-Identity Work: A Core Process of Sustaining, Restoring, and
Enhancing Resilience ..............................................................................80
Synopsis......................................................................................................80
Part 1: Normalizing-identity work through the form of narrative practices ....81
Summary..................................................................................................92
| Part 2: Normalizing-identity work through the form of highly valued activities | 93 |
| Part 3: Attending to the technological, social, and structural environment | 110 |
| CHAPTER FOUR: DISCUSSION AND CONCLUSIONS | 131 |
| Synopsis | 131 |
| Integrated Summary of the Findings | 131 |
| Discussion of the Findings in Relation to the Literature | 133 |
| Contributing to the conceptual dialogue on well-being | 133 |
| Relating psychosocial and structural adversities to identity | 135 |
| Unpacking the notions of normality | 136 |
| Viewing identity work as a core process of resilience | 139 |
| Shifting attention to the environment’s role in resilience | 145 |
| Discussion of the Findings in Relation to Implications for Practice | 148 |
| Facilitating identity work through multiple mediums of choice | 149 |
| Exploring well-being therapy for early psychosis intervention | 151 |
| Turning towards the ‘have-nots’ of specialized early psychosis services | 153 |
| Considering the potentially paradoxical effects of service provision | 154 |
| Discussion of the Findings in Relation to Implications for Future Research | 155 |
| Study Strengths and Limitations | 157 |
| Concluding Remarks | 159 |
| EPILOGUE | 160 |
| REFERENCES | 170 |
| APPENDICES | 196 |
| Appendix A: Social and demographic information form | 197 |
| Appendix B: Consent to be contacted form | 199 |
| Appendix C: Participant consent form | 201 |
| Appendix D: Illustration of a participant thematic map | 207 |
| Appendix E: Example of process used to construct found poetry | 208 |
LIST OF TABLES

Table 1. Socio-demographic characteristics of the sample ..........................................................51
Table 2. Interview guiding questions and probes ........................................................................56
Table 3. Quality appraisal criteria ..............................................................................................67
Table 4. The dimensions of well-being .......................................................................................73
Table 5. Emic meanings of normal .............................................................................................75
Table 6. Three types of narrative practices and associated strategies ......................................82
LIST OF FIGURES

Figure 1. Overview of the data collection process .......................................................... 53
Figure 2. Overview of the combined analytical framework ............................................. 62
Figure 3. Conditions that catalyze normalizing-identity work ........................................ 80
Figure 4. Five C’s: Well-being enhancing experiences derived from engaging in highly valued activities ........................................................................................................... 93
Figure 5. Photograph from Flower: Art making and well-being ..................................... 95
Figure 6. Mindmap from Goddess: Singing and well-being ........................................... 99
Figure 7. Photograph from Lily: Listening to music and well-being ................................. 100
Figure 8. Photograph from Ross: Practicing on the guitar and well-being .................... 101
Figure 9. Mindmap from Lily: Going to work and well-being ........................................ 103
Figure 10. Photograph from Kevin: Taking care of pets and well-being ......................... 106
Figure 11. Mind map from Kevin: Technology and well-being ....................................... 112
## LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPIP</td>
<td>Early Psychosis Intervention Program</td>
</tr>
<tr>
<td>YMHP</td>
<td>Youth Mental Health Program</td>
</tr>
<tr>
<td>SRO</td>
<td>Single Room Occupancy</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

Gratitude is the memory of the heart¹

It is with heartfelt appreciation that I express my gratitude to a number of individuals that have played a key role in supporting my academic journey.

First and foremost, I would like to acknowledge the 17 young individuals who participated in this research project and willingly shared their life experiences with me. Undoubtedly, their stories and perspectives were critical in helping to bring this work into fruition. It was an honour to get to know them, and I have been transformed and humbled by their courage and resilience.

I am also grateful to the service providers and program leaders across the two sites of recruitment for their enthusiasm and support of this work, as well as facilitation of the recruitment process.

Special gratitude is extended to my supervisory committee members: Dr. Melinda Suto, my supervisor, for her commitment, encouragement, feedback, and support – Melinda has accompanied me from the beginning and right to the end of my academic studies, with enthusiasm and dedication as a mentor, for which I am grateful; Dr. Jim Frankish, my co-supervisor, for providing insightful feedback and asking critical questions at key points during the research process – I also appreciate the supportive ‘chats and stories’ along the way that bridged academia with life more generally; Dr. Carl Leggo, for being a driving force of creative inspiration and undoubtedly a constant light throughout my academic journey; Dr. Michael Ungar, whose scholarly work in resilience research provided the frame through which this project was conceived, I am ever so grateful for his involvement in this project and the valuable feedback and support he provided along the way; and, Dr. Ashok Malla, for his feedback and critical questions posed at key points during the research process, and also for his wholehearted support of my professional journey in the field of early psychosis.

What would a learning experience in doctoral studies be without the camaraderie and support of one’s friends and peers inside and outside academia? There are many to name here, but special thanks to: Hana Albannay, Dana Anaby, Regina Casey, Evelyn Cornelissen, Heather Colquhoun, Sandra Hale, Leslie Hilford, Thomas Holmes, Emily Jenkins and other Knowledge Translation Trainee Collaborative peers, Eric Macnaughton, Tahereh Mosavi, and Mineko Wada. I have appreciated our conversations about research, academia, clinical work, and life; our collaborative work; and, also the encouragement and support along the way.

¹ French proverb attributed to educator Jean Massieu
I am also grateful to a number of colleagues and/or mentors who have contributed to the enrichment of my academic journey through collaborations either on papers, research projects, teaching, or other academic related activities: Drs. Carol Adair, Jayne Barker, Simon Davidson, Elliot Goldner, Tal Jarus, Eric Latimer, Nicol Korner-Bitensky, Myra Piat, Sam Sheps; and, Professor Michael Lee.

I also would like to thank the two university examiners: Drs. Sheila Marshall and Elizabeth Saewyc, for their feedback and suggestions related to this work. It has been an honour to have this work reviewed by scholars in identity, stigma, and resilience. As well, I extend my gratitude to the external examiner, Dr. Ross Norman, a scholar in the field of early psychosis, for accepting to review this dissertation and for providing helpful feedback and suggestions.

Thank you also to faculty and support staff within the University of British Columbia’s Department of Occupational Science and Occupational Therapy as well as the Graduate Programs in Rehabilitation Sciences, and in particular to Drs. Catherine Backman, Lyn Jongbloed, Bill Miller; and, staff: Tracy Henderson, Kathryn Lewis, Heather Swallow, and Sally Clark.

I would like to acknowledge the following institutions, agencies, and programs for providing financial support during my doctoral studies: Canadian Institutes of Health Research (Banting-Best Doctoral Scholarship program); University of British Columbia (Four Year Fellowship award program); Canadian Occupational Therapy Foundation (Doctoral Scholarship award program); Western Regional Training Centre for Health Services Research (Doctoral Student Affiliate program); Canadian Institutes of Health Research (Quality of Life Training Program in Rehabilitation Research); and Knowledge Translation Canada (Doctoral Training Fellowship program). As well, thank you to the: Canadian Society of Occupational Scientists (Award in Student Scholarship), Canadian Institutes of Health Research (Institute Community Support), Disabilities Health Research Network, and BC Mental Health and Addictions Research Network for providing financial support for disseminating this research.

I am deeply grateful to my parents for always encouraging my educational pursuits and for being willing to help in any way they can. Thank you to my siblings, sister-in-laws, niece and nephew for providing critical moments of ‘activities of daily living support’ and for encouragement and faith along the way.

Last, and foremost, a big thank you to my husband, Sunil, who several years ago, conceived of an idea that I should pursue a PhD, and who stood by me every step through the process. He has provided unwavering support in numerous ways (e.g., emotional, technical, editorial, instrumental), not the least of which include giving valuable feedback on this work, and being the best kind of life coach one could ever have. What can I say? You’re wonderful; and, I love you.
To my mom, dad, and husband

For bestowing upon me a living testament of resilience
PROLOGUE

This research study is situated within the specialized field of early psychosis\textsuperscript{2} intervention. In this context, youth recently diagnosed with psychosis\textsuperscript{3} have been the subject of plentiful research over the past two decades; yet, their narrative accounts have rarely been privileged, heard, and actively engaged in the research process.

My professional journey in the field of early psychosis began twelve years ago when I was recruited by the McGill University Health Centre in Montreal, Canada, to provide psychosocial interventions to young people within the context of an early psychosis intervention clinic. Since then, I have had the privilege to work with youth recently diagnosed with psychosis and their families, in different health care settings, and through a variety of roles ranging from clinical case manager, occupational therapist, and clinical program coordinator. In 2008, I felt the time was optimal to build on my clinical experience, and develop skills to conduct research that engaged patients and their families. Ultimately, I felt compelled to give patients a platform through which they could communicate their knowledge, such that this process could then help improve services provided to them. This step into the realm of research and academia marked an important turning point in my professional and personal journey.

I begin this dissertation with a personal narrative that bridges an impactful moment from early in my clinical career with observations made during the fieldwork of this study. This section of the dissertation is titled as a prologue because it is meant to serve as a separate, yet complementary introduction to the dissertation.

More than a decade ago, I was working as an occupational therapist in an early psychosis intervention clinic. In this setting, we were three health care professionals providing services to young people recently diagnosed with psychosis: a psychiatrist, a nurse, and myself. My role was to support clients in their goals related to returning to work, school, and other activities of community living.

\textsuperscript{2} Psychosis refers to a mental state that involves symptoms such as: hallucinations, delusions, formal thought disorder, and disorganized, bizarre, or inappropriate behaviour. These symptoms are present on a continuum of severity.

\textsuperscript{3} Youth recently diagnosed with a psychotic disorder is here referred to as individuals between the ages of 16-24 who have received a diagnosis of a psychotic disorder in the last three years.
One day, I took a young man by the name of John to the Wellington Centre, a rehabilitation centre offering recreation, employment, and community integration activities to individuals of all ages with mental health disorders. John had expressed an interest in carpentry and the Wellington Centre had a woodworking workshop. It seemed like a good fit in terms of getting John involved in meaningful activities.

We visited the centre on a sunny afternoon, and were offered a tour of the various programs. I was quite impressed. The visit reinforced the wonderful things I had heard about it in conversations with other colleagues. Although John was fairly quiet throughout the visit, I was not overly concerned as this was consistent with his nonverbal demeanor. Immediately upon leaving, however, John stated to me in a rather stern voice, “Don’t ever take me to a place like that again! I’m not sick, like those people.” I was numbed silent for seconds, and then managed to mend this momentary rupture in our therapeutic relationship; albeit somewhat clumsily.

A couple of years later, I started working as a case manager in a comprehensive medical and psychosocial early psychosis intervention program. The program adopts best practices in the field of early psychosis intervention. Within this context, the philosophy I was introduced to echoed John’s message to me: that young people experiencing early psychosis should be given opportunities to integrate within the ‘mainstream’ of society. That meant that we, as case managers, should avoid making referrals to recreational, employment, housing, education services that are solely dedicated to people with mental illness.

Last year, within the context of conducting the present study, I became familiar with another early psychosis intervention program. This program is also comprehensive in terms of the services it offers. Young people have access to a case manager, psychiatrist, peer support workers, and occupational therapy services. In meeting with young people receiving treatment from this program, I began to observe the pattern that they were often referred to services and organizations dedicated to individuals with mental health concerns by their case managers and occupational therapists. I was perplexed by this observation given my socialized counter-orientation to such practices. To my surprise, however, I came to notice that some of the young people were nonchalant and even to a certain extent appreciative about receiving housing, employment, and recreation services in settings specialized for individuals with mental illness, whereas others, like John, to my expectation, emphatically resisted the same possibilities. Hence,

---

4 John is a pseudonym.
I began to wonder, ‘what was going on here?’ In other words, an unanticipated question within the context of this unfolding inquiry emerged: how could it be explained that young people exposed to the same well-intentioned services, respond to, and experience them in starkly different ways?
CHAPTER 1: INTRODUCTION AND LITERATURE REVIEW

Synopsis

Using a qualitative approach, combining the methods of grounded theory and narrative inquiry, this study sought to contribute to the understanding of how youth recently diagnosed with a psychotic disorder sustain, restore, and enhance their resilience, and how aspects of the environment, and the activities they engage in, support and/or hinder this process.

Chapter 1 provides a review of the relevant literature, first by introducing the health issue of psychotic disorders and their impact on young people, their families, and society. This is followed by: an introduction to the specialized approach of early psychosis intervention, a review of the evidence for this approach, and a discussion on the treatment challenges and related gaps in the literature. The need for research based on the experiences and perspectives of young people recently diagnosed with psychosis is discussed, and a theoretical argument for research using a resilience framework is presented. Next, the construct of resilience is reviewed from a historical, conceptual, and methodological perspective. The chapter concludes with the present study’s research questions and objectives.

Chapter 2 describes the paradigmatic perspectives and methodological framework that guided the inquiry, and also presents a rationale for adopting a combined methodological approach. This is followed by a description of the research setting, the process for sampling and recruitment, and an overview of the data collection and analytical framework. The chapter concludes with a discussion on the complexities associated with quality appraisal in qualitative research, presents a set of universal criteria that can be considered for the purpose of appraising the present study, and provides examples of how these criteria were addressed in the implementation of this research.

Chapter 3 presents the findings in two major parts. Part 1 explains participants’ meanings of well-being, the inextricable link between well-being and identity, and the subtext of normality embedded in participants’ strivings towards, and experiences of well-being. Part 2 explicates the

---

5 Parts of this chapter are derived from the following peer-reviewed, published paper: Lal, S. (2010). Prescribing recovery as the new mantra for mental health: Does one prescription serve all? Canadian Journal of Occupational Therapy, 77, 82-89. doi: 10.2182/cjot.2010.77.2.4
6 Diagnosed in the last three years.
process of resilience-sustaining, restoring, and enhancing identity work, which involves interrelated pathways of engagement in narrative practices and highly valued activities.

Chapter 4 discusses the findings within the context of the theoretical and empirical literature on resilience, well-being, and recovery in early psychosis. The implications of the findings for future research and practice are also highlighted. An integrated summary of the findings, articulated through five key messages, is first presented and then discussed in relation to the literature, implications for practice, and directions for future research. This chapter concludes with comments on the strengths and limitations of the study. Finally, an epilogue, containing key messages that participants would like to convey to service providers and other young people is included at the end of the dissertation. Participants’ responses are re-presented therein through the method of found poetry.

This first chapter, containing the literature review, begins by providing background knowledge on psychotic disorders and situating this health issue within the context of service provision and treatment challenges.

**Psychotic Disorders: Prevalence, Symptoms, Morbidity and Mortality**

Psychotic disorders are a group of disorders associated with the following diagnoses: schizophrenia, schizophreniform disorder, schizoaffective disorder, bipolar I disorder with psychotic symptoms, major depression with psychotic features, substance induced psychosis, brief psychotic episode, and psychosis not otherwise specified (American Psychiatric Association, 2000). The lifetime prevalence of psychotic disorders is 3% (Perala et al., 2007), with incidence rates being particularly high among late teens and young adults, and males having a two-fold risk in comparison to females (Amminger, 2006; Garety & Rigg, 2001).

Psychotic disorders can be considered among the most disabling health issues affecting young people today. Psychotic disorders involve symptoms such as hallucinations, delusions, disorganized thoughts/behavior, poverty of thought and affect, apathy, and emotional withdrawal (American Psychiatric Association, 2000). Such symptoms can significantly impede daily functioning, and derail transitions towards achieving educational, recreational, employment, lifestyle, relationship, and autonomy milestones. In fact, symptoms of psychosis are associated with three of the top five leading causes of disability in the world (major depression, bipolar
disorder, and schizophrenia) for individuals between the ages of 15-44 (World Health Organization, 2001).

Several types of morbidity, mortality, and social concerns are associated with having a psychotic disorder. For example, young people with these disorders have high rates of: substance abuse (Lambert et al., 2005; Malla et al., 2008), suicidal ideation and behaviour (Nordentoft et al., 2002), cardiovascular disease and type II diabetes risk factors (Graham, Cho, Brownley & Harp, 2008; Ryan, Collins, & Thakore, 2003), social anxiety (Birchwood et al., 2007), depression (Romm et al., 2010), and unemployment (Killackey, Jackson, Gleeson, Hickie, & McGorry, 2006).

Beyond the direct effects on young people and their families, psychotic disorders also incur important social and economic costs (McGorry, 2012). In Canada, for example, schizophrenia accounted for 1.7% of national health care expenditures, or 2.02 billion dollars, in 2004 (Statistics Canada as cited in Goeree et al., 2005). The immediate and long-term effects of psychotic disorders for young people, their families, and society, highlight the importance of a synergized effort at the levels of policy, research, and practice to prevent the disabling consequences of this health issue.

The Promise of Early Intervention

Fortunately, in the past 20 years, a promising international movement in the development, evaluation, and implementation of a specialized early psychosis intervention approach has emerged with the ultimate goal of improving the quality of life of young people affected by psychotic disorders. The broad and burgeoning body of research literature representing this advancement in clinical practice can be conceptualized into two areas. The first distinct area within the field of specialized early psychosis intervention involves reducing the delay in treatment of psychosis, otherwise referred to in the literature as the duration of untreated

---

7 A third research area also exists, but is not directly pertinent to the present study. It pertains to the identification of individuals considered to be at ultra-high risk for developing psychosis, based on meeting a number of criteria (e.g., age, family history of psychosis, sub-threshold symptoms of psychosis, deterioration in social functioning), and provision of psychosocial and pharmacologic interventions to this population. This field of work remains in clinical equipoise given the potentially deleterious effects of exposing youth to either unnecessary or harmful treatments, diagnostic mislabeling, and stigma (McGorry, Killackey, & Yung, 2008, p. 151).
psychosis (DUP). DUP is the time between the onset of symptoms of psychosis at a threshold level for diagnosis of a psychotic disorder and the initiation of antipsychotic medication. It is also recognized that the initiation of comprehensive treatment that includes psychosocial interventions could justifiably be considered as an end point of DUP in addition to medication only. The focus on reducing DUP is based on replicated evidence that the duration of untreated psychosis is associated with poor clinical and social outcomes (Marshall et al., 2005; Norman & Malla, 2001; Norman et al., 2007; Perkins, Gu, Boteva, & Lieberman, 2005), as well as significant distress for patients and those close to them. In other words, the longer a person experiences symptoms of psychosis without receiving treatment, the more likely this will negatively affect his/her functioning at school, work, and interpersonally (Yung, 2012). A detailed discussion on DUP and a review of interventions targeting the reduction of DUP is offered elsewhere (Malla, Lal, Vracotas, Goldberg, & Joober, 2010).

The second distinct area that is addressed in the early psychosis literature involves the first five years after being diagnosed with psychosis (McGorry, Killackey, & Yung, 2008). Referred to as the critical period (Birchwood, Todd, & Jackson, 1998), this is the time during which clinical and psychosocial interventions are considered to have the highest impact for preventing disabling consequences associated with the disorder. Specialized early psychosis intervention services at this stage involve provision of medication treatment (usually novel antipsychotics are recommended) and psychosocial interventions, delivered by a multidisciplinary team. Psychosocial interventions, in individual and group format, are provided to both youth and their families in a manner that is timely and sensitive to the stages of recovery. Psychosocial interventions include: education on psychosis, treatment, and recovery; psychological and behavioural interventions pertaining to a range of areas such as lifestyle management, relapse prevention, skills training; and case management to help patients and their families navigate pathways towards recovery (Malla et al., 2010; Malla, Norman, McLean, Scholten, & Townsend, 2003).

There is compelling cumulative evidence from naturalistic and experimental studies which support the effectiveness of specialized early psychosis services delivered to young people following the onset of a psychotic disorder (McGorry, Nelson, Goldstone, & Yung, 2010; Yung, 2012). Results from randomized controlled trials indicate that an early psychosis intervention approach yields more benefits in terms of symptomatic and functional improvements when
compared to treatment as usual (Craig et al., 2004; Garety et al., 2006; Harvey, Lepage, & Malla, 2007; Petersen et al., 2005). For example, Petersen et al. randomly assigned 547 patients to either specialized early psychosis services or generic mental health services, within the context of the OPUS trial conducted in Denmark. The specialized treatment group demonstrated better outcomes in terms of improvements in symptoms and function at 1 year. Moreover, significantly fewer patients in the specialized treatment group were homeless or living in shelters at 1 year follow up. Similar results were obtained by another trial conducted in the U.K. (Lambeth Early Onset trial) in which better rates of compliance with medication and involvement in educational and vocational activities were observed in the specialized treatment group at 12 and 18 months follow-up (Garety et al., 2006).

**Treatment Challenges and Gaps in the Research Literature**

While there is promise in the evidence described above for improving the outcomes of young people diagnosed with a first episode of psychosis, the need to develop better interventions for this population continues to be of high priority (McGorry, 2012). There remain ongoing treatment challenges that are of important concern to clinicians working with this population. These concerns are also associated with gaps in knowledge that warrant further research attention. Several of these treatment-related challenges and their associated gaps in knowledge are outlined here.

First, the long-term effectiveness of specialized early psychosis intervention services is unclear given the current state of evidence. While randomized controlled trials indicate the short and medium term effectiveness (i.e., for the first two years) of specialized services in reducing symptoms and improving function, results from longitudinal studies suggest that maintaining outcomes over the longer term (i.e., at 5 years) remains a challenge. For example, symptomatic and functional gains achieved at two years in the OPUS trial were not sustained at 5 years (Bertelsen et al., 2008), after patients were transferred to primary care following two years of specialized services. It is important to note however that a recent Canadian study found that patients receiving a lower intensity of specialized early psychosis services (following an initial two year period of receiving higher intensity treatment), maintained symptomatic benefits between two and five years; moreover, further improvement in global functioning was observed.
during that same period of time (Norman et al., 2011). Thus, questions remain regarding the long-term sustainability of gains made in the first two years of receiving specialized early psychosis services, how long this type of treatment is needed to maintain gains longitudinally, and at what level of intensity.  

Second, it is unclear which aspects of specialized early psychosis intervention services are most critical for achieving and maintaining outcomes. As Bosanac, Patton, and Castle (2010) highlighted, there are problems associated with disaggregating the components of such services within the context of a research study. Third, there is the challenge of engaging individuals with a first episode of psychosis, a concern that has been expressed by clinicians as being of high importance (Compton, 2005; Lester et al., 2009). Beyond initial engagement, sustaining patient involvement over the course of the two to five year critical period is also considered to be a treatment challenge (Malla et al., 2010). Studies indicate that approximately one in four patients receiving specialized services for a first episode psychosis discontinues treatment (e.g., Conus et al., 2010; Turner, Smith-Hamel, & Mulder, 2007). In a sample of 288 patients followed for 1 year, Turner et al. found that a 24.6% rate of disengagement from services was associated with factors such as ongoing substance use, longer duration of untreated psychosis, lower level of insight at entry into the program, lower level of psychosis symptoms, and diagnoses of non-affective psychosis. In a more recent study of 786 first episode psychosis patients followed for 18 months, Conus et al. identified factors such as ongoing presence of substance use disorder, lower severity of illness at baseline, a forensic history, and living without family as predictors of service disengagement in 23.3% of the sample. However, their study was not able to account for other factors that can contribute to service disengagement such as patients’ and parents’ perspectives of the services they received. Service engagement challenges may also be related to factors associated with the mental health delivery system, the level of integration between components of the system (primary vs. specialized care), patients’ willingness to accept treatment, the skills of service providers to engage and sustain engagement of patients and their families (Malla et al., 2010), and the types of interventions delivered in relation to their fit with patients’ needs. It has also been suggested that engagement challenges may stem from providers’

---

8 Additional research is currently underway for contributing answers to these questions. For example, a randomized controlled evaluation of continued specialized early psychosis intervention treatment for three years following an initial two year treatment period versus follow up in routine care (after an initial two years of specialized treatment) is taking place at McGill University (personal communication, Ashok Malla, July 26, 2012).
lack of understanding of patients’ cultural beliefs, values, illness perceptions, and help seeking behaviours (Rathod, Kingdon, Smith, & Turkington, 2005).

Fourth, relapse rates of young people receiving specialized services for early psychosis, although lower than in routine care (55% at two years; Robinson et al., 1999), are unacceptably high at 30% (Malla et al., 2008). Relapses are associated with social, academic, and employment disruption as well as increased family burden and important health care costs related to rehospitalisation (Almond, Knapp, Francois, Toumi, & Brugha, 2004; Penn et al., 2005). In a fifth related matter, substance use disorders are highly prevalent in this population; the rates ranging between 30-62% across studies (Lambert et al., 2005; Malla et al., 2008). Substance use disorders are associated with: high rates of relapse (Malla et al., 2008) even with full adherence to medication (Levy, Pawliuk, Joober, Abadi, & Malla, 2012); and, reduced functional outcomes (Wade et al., 2007). The sixth challenge is functional recovery, which is measured in the literature in relation to employment, education, social relationships, self-care, housing and financial management. A review of longitudinal studies examining the functional outcomes of youth receiving services for early psychosis indicated that a significant proportion of patients continue to demonstrate poor functional improvements (Malla & Payne, 2005).

**Limited attention to the psychosocial issues of recovery**

While achieving social and functional recovery is of considerable importance for patients, families, service providers, and policy-makers (Malla & Payne, 2005), research conducted within the early psychosis intervention field is predominantly focused on symptomatic outcomes (Killackey, Yung, & McGorry, 2007). Other relevant and environmentally based domains of young people’s lives such as experiences of housing, employment, education, service engagement, community living, daily activity engagement, substance use, relationships, community support services, have been given limited attention. Moreover, while it is known that the ways in which individuals with psychotic disorders cope with symptoms, life stressors, and psychiatric illness more broadly, play an important role in the course and outcome of the illness (Philips, Francey, Edwards, & McMurray, 2009; Yanos & Moss, 2007), limited attention has been placed on the broader issues and processes of well-being, coping, psychosocial recovery, and resilience in the first episode psychosis population; albeit with some relevant exceptions.
(e.g., Jackson, Knott, Skeate, & Birchwood, 2004; Macdonald, Pica, McDonald, Hayes, & Baglioni, 1998; Tait, Birchwood, & Trower, 2004; Thompson, McGorry, & Harrigan, 2003; Uzenoff, 2010; Windell & Norman, 2012; Windell, Norman, & Malla, 2012). For example, the construct of well-being captures important aspects of recovery such as personal growth, which are not adequately addressed in the early psychosis literature (Uzenoff et al., 2010). The construct of resilience has also been minimally examined in the context of populations with mental illness (Breedlove, 2006).

In studies that have attempted to address issues such as coping in first episode psychosis populations, here again, the focus has been predominantly on symptoms (e.g., Boschi et al., 2000; MacDonald et al., 1998; Pallanti, Quercioli, & Pazzagly, 1997; So & Wong, 2008). Moreover, there is a research practice herein of seeking to identify which types of broad approaches to coping are associated with better outcomes (e.g., Boschi et al., 2000; active-behavioural, versus active-cognitive, versus avoidant). Lazarus (2000) however, cautions that pitting coping categories against each other renders interpretations that oversimplify a complex process. Moreover, the categorization and comparison of behavioural versus cognitive strategies (e.g., as applied in Boschi et al.’s study) is limited in terms of meaning. For example, listening to a song in response to auditory hallucinations can be a behavioural strategy, but also can be a cognitive one, as the individual may be gravitating towards listening to lyrics that facilitate shifts towards positive thinking (So & Wong, 2008). Additionally, few attempts have been made to elicit the types of stressors considered to be of most concern to youth themselves, the meanings of these stressors, how they overcome them, and how the environment supports and/or hinders their ability to cope. Contemporary coping experts also suggest that attention needs to be placed on future oriented coping (Folkman & Moskowitz, 2004; Roe, Yanos, & Lysaker, 2006). Attending to the preventative and proactive coping processes that help increase young people’s capacity to cope with stress more generally is an example of what a future oriented coping approach to research would entail (Schwarzer & Tauber, 2002).

**Limited attention to narrative perspectives**

While a burgeoning body of literature accumulated over 20 years has focused on young people diagnosed with a first episode of psychosis, surprisingly very little of it actually stems from their
stories of experience. Limited focused attention, for example, has been placed on young people’s narrative perspectives in relation to the treatment challenges described in previous sections (e.g., service engagement, psychosocial recovery). In fact, a recent review of qualitative research in the field of early psychosis conducted by Boydell, Stasiulis, Volpe, and Gladstone (2010) identified only 27 discrete studies, of which 12 (44%) were conducted with young people. This handful of studies pertained to young people’s experiences and perspectives of early psychosis services, employment, and their subjective experiences of psychosis and recovery. The rest of the studies pertained to the prodrome, pathways to help seeking, and/or addressed other relevant stakeholder groups (e.g., parents, siblings). Since Boydell et al.’s (2010) review, a few additional studies have been published that pertain to young people’s perspectives of specialized early psychosis services (e.g., Lester et al., 2011), and on the topic of recovery (e.g., Windell & Norman, 2012; Windell et al., 2012). Nonetheless, despite these recent contributions, the research practice of eliciting the narrative perspectives of young people recently diagnosed with psychosis remains nascent at best.

The treatment challenges and gaps in the literature heretofore reviewed, call attention to the need for a shift in focus that expands the early psychosis research field towards understanding psychosocial recovery and well-being from the narrative perspectives of young people themselves. This warrants a broader, salutogenic approach that expands into the various life domains and daily experiences and contexts of young people’s lives. Salutogenic refers to a perspective that is focused on the personal and environmental resources available to individuals that promote their access to health and well-being (Antonovsky, 1996). A salutogenic understanding can be facilitated using the narrative and socio-ecological9 concept of resilience.

**Shifting Focus towards Narrative, Resilience Oriented Perspectives**

*A simple change of focus and emphasis could deliver better outcomes for people with potentially severe mental and substance use disorders (McGorry, 2007, p.1).*

The phenomenon of resilience, represented by the human capacity to overcome adversity, has attracted a surge in policy, practice, and scholarly interest particularly over the past decade.

---

9 Refers to a focus on the interactions between individuals and their environment (proximal and distal) and the effects of these interactions.
Resilience as a construct is increasingly associated with wide ranging appeal and application across a number of health and social service related disciplines, and has sparked interdisciplinary interest. In Canada, at the policy level, resilience has become a focal point of initiatives within health and social service sectors (e.g., Canadian Institutes of Health Research, Institute of Human Development, Child and Youth Health, 2006; Human Resources and Social Development Canada, Policy Research Directorate, 2009); and, at the scholarly and practice levels, resilience is increasingly explored and examined in several fields including developmental psychology (e.g., Luthar, Cicchetti, & Becker, 2000), social work (e.g., Bottrell, 2009), nursing (e.g., Kralik, van Loon, & Visentin, 2006), and rehabilitation sciences (e.g., White, Driver, & Warren, 2008). Handbooks on resilience have also been recently published showcasing resilience research from different epistemological and/or social or clinical perspectives (e.g., Reich, Zautra, & Hall, 2010; Ungar, 2012). A driving force that underpins this research on resilience is to develop knowledge on protective mechanisms influencing positive outcomes in the context of adversity, to ultimately better inform the planning and development of health and social service policies and interventions (Luthar et al., 2000).

In the presence of adversity, resilience refers to individuals’ efforts to navigate and negotiate resources considered meaningful for well-being and the environment’s capacity to support this process. In other words, the capacity to cope in the face of adversity is a function of an individual’s navigation towards and negotiation with what is available, accessible, and meaningful in the environment (Ungar, 2011). Such a definition shifts the balance of attention towards a more holistic perspective by considering and attending to the critical role the environment plays in supporting and/or hindering young people’s process of navigating towards their well-being.

Applied within the context of a first episode psychosis population, understanding young people’s resilience, from a social-ecological and narrative perspective, entails considering their perspectives on well-being, the adversities and difficulties they face, and, the natural efforts they initiate and sustain to cope and overcome challenges; moreover, it necessitates an analytical frame of reference on how the environment supports and/or hinders this process, across various domains of their lives. As Teram and Ungar (2009) have suggested, such an approach can be useful in helping to inform practice that is relevant to youth themselves. A resilience framework is also in line with the salutogenic, strengths based, and recovery oriented perspectives that are
increasingly adopted in the psychiatric literature (e.g., see Roe & Chopra, 2003; Roe, Chopra, Wagner, Katz, & Rudnick, 2004) and key mental health policy documentation in North America (e.g., Mental Health Commission of Canada, 2012; New Freedom Commission on Mental Health, 2003).

**Conceptualizing the Bridge between Resilience and Recovery**

Resilience and recovery are two related phenomena, each important for contributing knowledge that can ultimately inform strategies and interventions to improve the mental health and well-being of populations. Both concepts are embraced within Canada’s recently released Mental Health Strategy (Mental Health Commission of Canada, 2012) and in the landmark report from the New Freedom Commission on Mental Health (2003) in the U.S.A. In the latter document, resilience and recovery are proposed as the two key concepts for guiding the transformation of the mental health care system. Moreover, increasing research on resilience that extends beyond the domains of symptom management has been articulated as one of four key recommendations for facilitating mental health reform (New Freedom Commission on Mental Health, 2003). Thus, these policy initiatives emphasize the importance for advancing knowledge on resilience and recovery to meaningfully inform and transform practices and interventions within the mental health care system. Yet, despite increasing policy and practice attention on these two concepts, limited conceptual and empirical work has been done in terms of how recovery and resilience relate to each other. Thus, a theoretical and empirical conceptual analysis of the bridge and distinctions between these two concepts is warranted, particularly as it pertains to individuals living with mental illness. The subsequent passages provide a starting point in this regard.

Recovery and resilience stem from two distinct bodies of theoretical and empirical literature. Both have a history of being conceptualized as outcomes and evolving towards incorporating process oriented perspectives. One can also observe an increasing call to the importance of attending to the subjective, narrative accounts and appraisals of individuals existing in both bodies of literature (e.g., see Bottrell, 2009; Windell & Norman, 2012). While authors have alluded to the related nature of recovery and resilience (e.g., Ridgway, 2001), there are inconsistencies in terms of how these relationships have been articulated. For example, at the level of policy, the recently released Mental Health Strategy for Canada (Mental Health
Commission of Canada, 2012) proposed that the concept of recovery be applied in the adult context, while resilience is suggested for application in the youth context. In this regard, resilience is incorporated into a broadened understanding of recovery:

The approach to recovery has been broadened to include the concept of well-being, so that, with some adaptations to the different stages of life, the principles of recovery can apply to everyone. With infants, children, and youth, for example, the focus is on becoming resilient and attaining the best mental health possible as they develop (p. 12). Thus, the Canadian strategy adopts a chronological developmental approach towards the conceptual distinction between recovery and resilience. The Canadian approach is bewildering as it is unclear why the concept of resilience would only apply to youth. Concurrently, various stakeholder groups have also expressed concerns regarding the application of the concept of recovery to the youth context (e.g., Frieson, 2007). For example, based on discussions with family members, researchers, advocates, service providers, and decision makers on the topic of applying the recovery concept in the context of youth mental health, Frieson (2007) reported that overall, there was a lack of consensus from stakeholders as to whether the recovery concept added anything new to frameworks currently being used in youth mental health, such as resilience. Concerns were also expressed regarding the confusion of the term recovery with “cure.” It is also interesting to note that in the context of research with youth being treated for a first episode of psychosis, participants commonly attributed recovery with an “end state” (p. 5) or outcome (Windell et al., 2012). Moreover, recovery language may be problematic (i.e., disengaging) to use with youth who do not necessarily identify with a psychiatric label and illness to recover from.

Elsewhere, I have reviewed the concept of recovery using Chinn and Kramer’s (1995) framework for critical reflection (Lal, 2010). In this review, I examined the concept of recovery based on how it has been studied and discussed in the mental health literature, from five perspectives: clarity, simplicity, generality, accessibility, and importance. This critical reflection identified issues regarding the limited representativeness of samples from which recovery has been conceptualized particularly in relation to culture, lifespan, and stages of illness (such as individuals experiencing the onset of psychosis). As such, further research with more representative samples is required before directly applying knowledge on the meanings and processes of recovery to younger populations experiencing early onset of illness, accessing
psychiatric care for the first time, and representing different social, economic, and cultural backgrounds. More recently, Windell et al. (2012) have also echoed similar recommendations.

In contrast to the Canadian Mental Health Strategy, the American New Freedom Commission on Mental Health’s (2003) approach to distinguishing the concepts of recovery and resilience is not bounded by a chronological developmental perspective. It defined recovery as: “The process in which people are able to live, work, learn, and participate fully in their communities,” and resilience as, “the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses — and to go on with life with a sense of mastery, competence, and hope” (p. 5). Thus, recovery is described as a broad process through which social functioning is achieved, whereas resilience refers to the personal and community qualities that contribute to that process. Others distinguish resilience and recovery in relation to the rate of improvement following trauma, with recovery conceptualized as encompassing a longer duration (Norris, Tracey, & Galea, 2009).

In a rare empirical effort, Breedlove (2006) undertook an exploratory analysis of recovery and resilience by comparing their underlying structures. A sample of 150 individuals diagnosed with severe and persistent mental illness completed questionnaires on resilience and recovery. The strength and direction of correlations between the measures were assessed and a factor analysis of items in the measures was completed. The two constructs were found to overlap, and also have unique factors; for example, competence and managing negative affect were among the distinguishing factors related to resilience. Breedlove concluded that the relationships between the constructs remain unclear. I would concur, particularly when considering the scales used. For example, Breedlove used the Connor-Davidson Resilience Scale (CD-RISC) (Connor & Davidson, 2003) to measure resilience. Several critiques could be raised regarding the psychometric properties of this scale particularly in relation to how items in the scale were generated. For example, Connor and Davidson identified the 25 items on the scale through a literature review of studies on resilient people as well as other interesting, yet potentially questionable sources for a measurement tool (e.g., the personal qualities of a heroic leader’s expedition in the Antarctic, which took place in 1912). Additionally, the CD-RISC does not account for the possibility of differences in ratings across life domains. For example, some individuals may identify with statements as more true in relation to their academic life versus their interpersonal life. A modification of the instrument to include these aspects might augment
the CD-RISC’s representation of resilience as a dynamic construct. It is also noteworthy that the factor analysis was constructed using a sample from the general population. Replicating the process with different samples (e.g., clinical), before concluding about the appropriateness of the items in the scale and generalizing about the stability of the structure to other population groups, is important to consider. As Portney and Watkins (2009) have suggested, a factor analysis with different groups can result in a different organization of the data. Evidently, more phenomenological and theoretical work needs to be done on resilience and recovery separately and in relation to each other, to arrive at an integrative model useful for application in populations with mental illness, and more specifically within the context of youth recently diagnosed with first episode psychosis.

In the present study, the following conceptual bridge and distinctions are made between the concepts of recovery and resilience as applied within the context of populations experiencing mental illness: recovery represents the broad transformational clinical, personal/psychological, self-care, occupational, and social process that individuals undergo as they navigate towards their well-being; whereas resilience represents the capacity to cope with adversity more generally. Adopting Ungar’s (2011) definition, resilience is reflected in individuals’ efforts to navigate and negotiate towards resources considered meaningful for their well-being, and the environment’s capacity to support this process. Thus, the capacity to cope with adversity is a function of processes existing at the interface between individuals and their environment. Using this distinction between the two concepts, I am proposing that the enhancement of resilience can promote the quality of the recovery process, and that both concepts can be usefully applied to populations across the lifespan.

A Conceptual and Historical Review of the Construct of Resilience

There is an extraordinary body of literature on human resilience that spans 40 years with the construct increasingly being examined in a range of adversity contexts and population settings, using different methodological approaches and theoretical models. This section provides an overview of the resilience literature from a conceptual and historical perspective, tracing its roots in epidemiological risk research within the field of developmental psychopathology, to contemporary constructivist and constructionist understandings. Gaps and concerns pertaining to
research on resilience, particularly in relation to the conceptual, methodological, and theoretical terrain are also highlighted.

As a concept, resilience originally stemmed from the field of physical sciences (Boyden & Mann, 2005), wherein it is referred to as the capacity of a material, organism, or ecosystem to absorb, reorganize, and recover from stress or strain (Holling, 1973). Applied to human beings, several overlapping waves of conceptual understanding of resilience and empirical focus can be observed. Resilience has conceptual roots in risk\textsuperscript{10} research conducted within the field of developmental psychopathology during the 1940’s and 1950’s. Researchers first brought attention to resilience through conducting research on the risk that children have for developing psychopathology (Masten, Best, & Garmezy, 1990).

Garmezy’s (1974a; 1974b) extensive review of studies illustrated that a key focus during the early period of risk and resilience research was to identify the strength and the nature of association between parents with mental illness (e.g., schizophrenia) and the development of psychiatric disorder in their offspring. For example, during the 1950’s, Michael Rutter, an internationally renowned child psychiatrist, and pioneering researcher in the field of resilience, conducted epidemiological research in the U.K. through retrospective investigation of the case records of children receiving psychiatric care and compared them to children receiving non-psychiatric, health related services (e.g., dental care). The group receiving psychiatric services had three times the rate of having a parent with psychiatric illness when compared to the other group of children, thus suggesting that having a parent with mental illness increases risk for developing psychopathology. Yet, it was also apparent that despite having the risk of parental mental illness, a proportion of children evaded psychopathology. These children, labelled as invulnerable (Anthony, 1974; Garmezy, 1974a, 1974b) or invincible (Werner & Smith, 1982), became the subjects of interest for understanding variations in adaptation and response to adversity (e.g., Anthony, 1974; Garmezy, 1974a, 1974b). Thus, during this early period, pioneering researchers sought to identify the factors associated with differential outcomes (e.g., developing disorder versus positive adaptation) from childhood risks such as having a parent with a mental illness, through prospective or retrospective study. Since then, the consideration of risk factors has extended beyond parental mental illness to include natural disasters (e.g.,

\textsuperscript{10} Risk and adversity pertain to factors that demonstrate the potential to affect an individual’s development or impede adaptive function.
earthquakes); traumatic experiences (family violence); and chronic adversities (growing up in poverty and/or in the presence of parental substance abuse) (Boyden & Mann, 2005; Luthar et al., 2000; Masten & Coatsworth, 1998; Masten & Wright, 2010; Werner & Smith, 1982).

Evidently, earlier research on resilience was focused on conceptualizing it as a trait (Ungar, 2011). In a second wave of understanding and empirical attention, protective factors in the individual, and factors in the individual’s environment, became increasingly recognized for their dual role in reducing the negative effects of growing up in adverse circumstances (Luthar et al., 2000). This dual importance of individual and environmental factors was illustrated, for example, through findings from Werner and Smith’s (1982, 1992; Werner, 1993) seminal study of risk factors associated with childhood development and adaptation. In a longitudinal study, they followed 698 children born in the year 1955 on the Hawaiian Island of Kauai from birth into adulthood. A third of the sample was identified as high risk due to being exposed to multiple risk factors such as perinatal complications, chronic poverty, parental mental illness, and experience of family instability during childhood. Contrary to expectations, a third of these children were then observed to develop well at age 10, 18, and 30 (measured, for example in terms of life satisfaction, lack of criminal record, absence of psychopathology). Protective factors associated with the positive outcomes observed were identified at three levels: the individual (e.g., internal locus of control, sociability), family (e.g., emotional support from parents), and community (e.g., support and/or opportunities through school, work or other). ¹¹ Other research has also demonstrated that protective factors exist at the aforementioned three levels. For example, research indicates that attachment, social support, intelligence, self-regulation, agency, mastery, self-efficacy, meaning-making, and cultural traditions are important for contributing to resilience (Masten & Wright, 2010). Nurturing these protective factors is argued to inoculate individuals in their ability to overcome adversities that emerge during the lifespan.

Seminal studies such as Werner and Smith’s (1992) have contributed to a more complex and contextually attuned notion of resilience. Their study highlighted the temporal variability of resilience over the lifespan. Children who were considered to be most at risk for obtaining poor psychosocial outcomes in adulthood demonstrated problems with coping during adolescence, but then surmounted adversity in significant ways during young adulthood. Resilience came to be

¹¹ It is important to note that these findings have been challenged through suggestions that those children who fared better, simply had less liabilities to begin with, thus conflating low-risk with resilience (Masten, Best, & Garmezy, 1990).
understood as being shaped by cumulative effects of adverse experiences throughout the life span (Rutter, 1985), and a function of a dynamic interaction between internal characteristics and external resources that allow an individual to cope when faced with adverse or challenging life circumstances (Rutter, 1993).

In a third wave of understanding, attention shifted away from perceiving resilience as some kind of inherent ‘magical’ quality, to conceptualizing it as a developmental process of adaptation available to all who are facing adversity (Masten, 2001). Moreover, scholars such as Rutter (2006), brought attention to the idea that exposure to adversity has the potential for contributing to resilience enhancement, referred to as a steeling effect. Resilience came to be defined as a, “dynamic process encompassing positive adaptation within the context of significant adversity” (Luthar et al., 2000, p. 543). Within this process-oriented perspective, researchers advocated moving beyond the identification of factors associated with risk and protection, to understanding how these factors operate contextually (e.g., Rutter, 1987). As Rutter (1987) stated, “Instead of searching for broadly based protective factors we need to focus on protective mechanisms and processes” (p. 317). To elaborate, Rutter (2006) asserted that attending to what people do in relation to adversity is important; in other words, their coping mechanisms as represented by subjective appraisals and personal agency. Thus, in this third wave of understanding attention was placed on examining underlying processes involved in contributing to variations in outcomes based on responses to similar adversities. In doing so, scholars also argued for the application of life-span approaches to studying resilience; integration of biological and psychosocial approaches; attention to meaning and agency; and, expansion of methodology to capture the process, contextual, and temporal aspects of resilience (Luecken & Gress, 2010; Masten & Wright, 2010; Rutter, 2006).

Next, in a fourth wave of understanding, concerns begin to emerge regarding inferential judgments in the resilience literature on what constitute adversity and successful adaptation (Masten, 2001; Ungar, 2004). These concerns arise from, and give rise to, an epistemological shift wherein the conceptualization of resilience is informed by constructivist and constructionist perspectives which have facilitated ‘seeing’ past and through the ways in which research on

---

12 Here I adopt Sparkes & Smith’s (2006) heuristic distinctions between constructivism and constructionism, whereby the former refers to attention on the inter-subjective, micro-psychosocial processes through the inner world of the participant, and the latter emphasizes consideration of the influence of social and cultural factors, language, and discourse on human behavior. These concepts are further discussed in Chapter 2.
resilience and its resulting knowledge have been assembled and produced hegemonically. Ungar (2004), for example, critiqued resilience research that focused predominantly on identifying predictive relationships and causality between risk and protective factors. He highlighted the limits of this type of work in being able to address the variability and complexity of how resilience manifests across cultures and contexts. He further casted light upon how emic\textsuperscript{13} perspectives of marginalized populations have been excluded from the predominant resilience research discourse. Engaging the perspectives of marginalized populations can help to better understand what constitutes risk, health, well-being, and adversity in different contexts and settings. In an illustrative example, Ungar’s (2001) research demonstrated that young people’s participation in delinquent activities (e.g., truancy, living on the street, negative peer associations) are ways through which they access experiences of well-being, belonging and empowerment, thereby challenging normative judgements on disordered behaviour.

Thus, in this fourth wave of understanding, researchers brought to the forefront of attention, and challenged the taken-for-granted, culturally-based, normative notions of risk and resilience. They argued that much of the research in this area is dominated by culture bound assumptions of what is an adverse circumstance, what is risk, and what constitutes successful outcome (Boyden & Mann, 2005; Ungar, 2003). It is within this social constructivist and constructionist context that researchers proposed and advocated for the active engagement and participation of young people in resilience research using qualitative approaches (Bottrell, 2009; Ungar, 2003; 2004).

In a fifth wave of understanding, attention shifts significantly towards the contextual aspects of resilience. Researchers argued that traditional approaches under-theorize the role of social and structural forces in shaping the process of resilience (Bottrell, 2007; 2009; Boyden & Mann, 2005; Ungar, 2011; 2012). Socio-ecological perspectives are valued for their utility in contributing to complex understandings of mutually interacting nested environments (Bronfenbrenner, 1977) on the process of resilience. It is asserted that resilience can be better understood through contextualized research that looks beyond individual level factors and takes into account the potential influences of the micro, meso, exo, and macro environments (Bronfenbrenner, 1977) in which individuals are situated (Bottrell, 2009; Ungar, 2011). Indeed, this assertion is supported by studies of young people’s narrative accounts, which illustrate that

\textsuperscript{13}Emic refers to the subjective perspective of the person being studied.
adversity exists in, and stems from a range of social and structural forces, including for example, local and distal discourses of stigma and stereotyping. In other words, experiences of adversity are demonstrated to be influenced by factors that are inextricably linked to the social, political, and economic environments in which youth live (Bottrell, 2009; Boyden & Mann, 2005). Moreover, this type of research has illustrated that in the context of social and structural adversity, young people strive forward in enhancing their identity and well-being through the subjectively meaningful resources they have accessible to them (Bottrell, 2007; 2009; Ungar, 2001).

For example, Bottrell (2007; 2009) conducted a qualitative analysis of the social contexts and narrative accounts of young girls growing up in an inner city public housing estate in Sydney, Australia. Their perspectives conveyed that the risk conditions of stereotyping and stigma produced more impact on their lives than the social conditions in which they lived. Findings lead to the argument for, and contribution to a social theory of resilience that accounts for the influence of social structures, local and distal discourses, and inequities on the experience of adversity and processes of adaptation. This type of contextually focused research elevates the importance of shifting the responsibility of resilience from the individual to society. Ungar (2011) further elaborated on this shifting of attention towards the social and physical ecologies of young people through the notion of decentrality, one of four principles he articulated as providing the socio-ecological basis for conceptualizing resilience.

**Research issues, limitations, and gaps in the literature**

Despite conceptual advances and burgeoning interest, a number of research issues, limitations, and gaps in the literature pertaining to the phenomenon of resilience warrant ongoing attention; these can be organized into three areas: conceptual inconsistencies; taken for granted assumptions; and scope of scholarship (Boyden & Mann, 2005).

**Conceptual inconsistencies.** The construct of resilience evades precise definition, in part due to contention surrounding the concepts and dimensions that define it. Moreover, in a

---

14 Patterns of social arrangements in society (including patterns of behaviours amongst, and between groups; and norms and practices that frame actions of a group).
related manner, a comprehensive theory explaining successful adaptation in response to adversity has yet to be developed (Boyden & Mann, 2005). This limits the possibility of measuring resilience through rigorous scientific process (Boyden & Mann, 2005; Luthar et al., 2000). Whereas some researchers specify resilience as a trait, or outcome, or process, others refer to it as some combination of these notions. To illustrate, resilience scholars Masten, Best, and Garmezy (1990) defined resilience as: “the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances” (p. 426). Additionally, there is no unified theory of resilience, and conceptual inconsistencies translate into the area of measurement; in this regard, there is concern that the development of scales and research in this field lack theoretical rigor (Luthar et al., 2000). While further conceptual consensus and theoretical development is warranted, it is also important to note that the aforementioned issues are not specific to the concept of resilience. Elsewhere, for example, I have raised similar concerns in relation to other applied concepts in the health related literature, such as recovery (Lal, 2010).

\textit{Taken-for-granted’ assumptions}. Much of the resilience literature is based on taken for granted, normative, preconceived, and culturally based notions pertaining to adversity, adaptation, and well-being. However, as Boyden and Mann (2005) and Ungar (2003, 2004) have explained, the perception of concepts such as adversity are subject to culturally and/or contextually derived meanings and specificities. In other words, western, middle-class notions of risk, adversity, adaptation, and resilience may not be directly applicable to populations and contexts that are informed by different value systems, beliefs, experiences, and socio-structural contexts. The field is challenged by questions such as: how are adversity and outcome criteria determined and by whose standards? Is successful adaptation determined by subjective conditions, such as well-being? Or, functional conditions, such as employment and academic achievement? Or, psychological conditions, such as the absence of a mental disorder?

\textit{Limited scope of scholarship}. The scope of resilience scholarship is limited in several areas. First, much of the research on resilience has been conducted in the North American context, which is inhabited by a minority of the world population. Thus, while a number of protective factors associated with positive adaptation in the context of adversity have been
replicated in the literature, the extent to which they are applicable across geographical settings and cultures is unclear (Boyden & Mann, 2005). Second, although the importance of context has been recognized in the resilience literature, research remains focused on individual processes of adaptation, with limited attention to social and structural processes (e.g., cultural practices, distal discourses, social positioning, social inequalities) (Bottrell, 2009; Bottrell & Armstrong, 2012; Boyden & Mann, 2005; Ungar, 2011). Third, adaptation, as an outcome of resilience, has been commonly defined by presence of both functional outcomes and the absence of psychopathology. In this regard, individuals with mental illness are automatically categorized as being ‘non-resilient’ thereby excluding them as sources to understand salutogenic processes. This categorical approach is problematic as it conflicts with longitudinal research demonstrating that between one half up to two-thirds of individuals, who have been diagnosed with schizophrenia, can and do recover to the point of leading functionally adapted lives (Harding, Zubin & Strauss, 1987). Moreover, the traditional perspective on resilience as the absence of psychopathology conflicts with research demonstrating that the absence of psychopathology does not necessarily equate to the presence of mental health/well-being (Keyes, 2005). Thus, instead of focusing on resilience as the absence of psychopathology, research could instead attend to resilience in terms of individuals’ personal agency and resourcefulness in managing or ameliorating their psychological and social situations.

Fourth, while much of the resilience literature pertains to youth, little of it is articulated from their narrative accounts and perspectives (Ungar, 2003, 2004). Concurrently, the limited research that does exist on the narrative accounts of youth suggests that differential outcomes in relation to adversity can be understood by centering attention on young people’s perspectives (e.g., see Hauser & Allen, 2006). Ungar (2003, 2004) has asserted that the practical limitations of extant research on resilience are partly attributed to the traditional, quantitative, positivistic, ways in which resilience has been conceptualized and studied. Moreover, he noted that resilience is a complex phenomenon that is represented by heterogeneity in outcomes, risks, protective factors, and processes; and has criticized quantitative approaches for being limited in ability to account for the myriad of contextual factors and temporal, geographical, cultural, and socio-economic variability inherent in the resilience process. Thus, there are tensions in the field with regards to the heterogeneity and homogeneity of what contributes to resilience and how it manifests.
In response to the debate and criticism on conventional research approaches to resilience, two new perspectives have been recommended: 1) a contextualized approach to understanding resilience in relation to cultural, social, and ecological factors, and 2) the use of qualitative methodology that “shift[s] from the perspective of the observer to the perspective of the participant” (Ungar, 2011, p. 8). Although there is compelling need for the application of qualitative approaches to enhance the contextualized understanding of resilience, with the exception of a few efforts (e.g., Bottrell, 2007; Hauser & Allen, 2006; Ungar, Brown, Liebenberg, Cheung, & Levine, 2008), systematic and rigorous study using such approaches has been limited (Ungar, 2003).

Qualitative methods are best suited for providing in-depth, contextualized, understanding of experiences and behaviours, in terms of how they are created and what meanings individuals ascribe to them (Denzin & Lincoln, 2005). Thus, personal narratives can enable access to understanding how individuals adapt to adversity. This is supported by research which increasingly demonstrates that narratives reflect both processes of adaptation as well as influence it (Hauser, Golden, & Allen, 2006). As Hauser et al. denote,

Stories are hubs in the wheel of our perpetual psychological work. From experiences we derive meaning; from meaning-making we imagine new actions; new actions lead us to new experiences; from new experiences we evolve new meanings—all in our real life contexts (p. 209).

A narrative approach to this study can help to understand how youth interact with elements in the environment to construct meanings, experiences, and processes of resilience. Moreover, adopting a qualitative, narrative approach, wherein youth are provided with opportunities to share their meanings and experiences of adversity and well-being, as well as their efforts to overcome challenges in their lives, is considered to be useful in helping inform practice that is relevant to youth themselves (Teram & Ungar, 2009). This is particularly noteworthy for the present study as it is situated within the specific clinical practice field of specialized early intervention for psychosis.

**Research Questions and Objectives**
Research questions

1. How do young people recently diagnosed with a psychotic disorder sustain, restore, and enhance their resilience (i.e., the capacity to navigate and negotiate pathways towards their well-being)?
2. How do the environment and activities young people engage in influence the process of sustaining, restoring, and enhancing resilience?

Primary objectives

1. To better understand the meanings, experiences, and processes of well-being and adversity from the perspectives of 15-20 young people recently diagnosed with a psychotic disorder.

Secondary objectives

1. To identify narrative practices employed by youth when discussing their well-being.
2. To examine the role of activities related to illness management, school, employment, social supports, leisure, and community living in sustaining, restoring, and enhancing resilience.
3. To explore how the environment shapes the sustaintment, restoration, and enhancement of resilience in youth recently diagnosed with a psychotic disorder.
4. To explore the role of informal and formal supports and services in sustaining, restoring, and enhancing resilience.
5. To compare and contrast the accounts of youth living in different socio-economic circumstances in relation to the process of sustaining, restoring, and enhancing resilience.

---

15 Environment here refers to the physical, social, cultural, economic, and political surroundings that humans are in direct (proximal) and indirect (distal) contact with.
16 Meanings refer to ideas and explanations about what a term, event, or phenomenon signifies/represents.
17 Experiences refer to personal events, situations, circumstances, and actions of young people accessed through their stories about those events, situations, circumstances, and actions.
18 Process, from a grounded theory perspective, refers to a series of human actions towards some end.
CHAPTER 2: METHODOLOGY

Synopsis

This study documents how young people recently diagnosed with psychosis sustain, restore, and enhance their resilience through an analysis of their narrative accounts. By shifting attention away from categorical outcomes and objects of measurement, the study sought to ground understanding on resilience from the perspectives of young people themselves. To facilitate this process, I applied a qualitative, interpretative approach that was emergent in design.

Fundamental to the undertaking of any qualitative inquiry is the foundational scaffolding of a coherent research design. Coherence refers to a clear linkage between the various elements of the inquiry process, starting from the research questions through to the representation of the findings; in other words, they are pieced together in a well-reasoned and commensurate way (Tracy, 2010). A qualitative research design is grounded in a paradigmatic stance, which contains assumptions about the nature of the phenomenon under inquiry (i.e., resilience) and how it can be known; a theoretical perspective, which contains the overarching principles through which the phenomenon can be understood; a methodology that provides the overall framework for choices related to data collection, analysis, and representation; and, the actual methods and tools used to enact the inquiry (Crotty, 1998). A key way in which a qualitative study can be appraised, in terms of its merits and integrity, is by considering the coherence between these various elements (Carter & Little, 2007). It is important, therefore, to provide sufficient description and rationale for the choices in constructing any particular research design.

This chapter describes the overarching framework through which the present study unfolded, and is organized in five sections. Section 1 (Positioning the research/er on a paradigmatic continuum) presents an overview of the paradigmatic and theoretical perspectives that broadly informed the development of the research questions and the process of inquiry. Section 2 (Making the case for a combined methodological framework) provides an overview of

---

19 Portions of this chapter, particularly sections two and four, are derived from the following peer-reviewed papers: Lal, S., Suto, M., & Ungar, M. (2012). Examining the potential for combining the methods of grounded theory and narrative inquiry: A comparative analysis. *The Qualitative Report, 17* (41), 1-22.
the key methodological traditions that guided the decision making process for data collection, analysis, and representation: grounded theory and narrative inquiry. In this section, I also present a comparative analysis of these two traditions across 12 methodological features and articulate the rationale for drawing methods from both of these traditions. Section 3 (Setting, sampling, and recruitment) provides an overview of the two settings from which participants were recruited, a description of the sampling strategy employed, and steps taken to recruit participants. It also describes the sample. Section 4 (Methods) presents the methods of data collection, data management, data analysis, and representation of findings. The chapter concludes with section 5 (Navigating the cornucopia of quality appraisal criteria), which provides an overview of the quality appraisal criteria landscape within the qualitative literature. This is then followed by an identification of a set of universal criteria which can be considered for the purpose of appraising the present study’s merits and integrity.

**Section 1: Positioning the Research/er on a Paradigmatic Continuum**

A paradigm of inquiry provides the filters through which any study takes place. A paradigm, which is also referred to as a researcher’s “worldview,” is a “set of basic beliefs” (Guba & Lincoln, 1994, p. 107) pertaining to the dimensions of ontology (the nature of reality), epistemology (ways of knowing); methodology (set of processes and steps used to acquire knowledge), and axiology (values influencing the process of inquiry, as they pertain to ethics, aesthetics, and spirituality) (Guba & Lincoln, 1994; 2005). Ontological, epistemological, methodological, and axiological assumptions and beliefs implicitly and/or explicitly shape the undertaking of any study (Denzin & Lincoln, 2005).

A taxonomy of paradigms can be a helpful heuristic for clarifying the beliefs that guide a research study. Guba and Lincoln (2005) proposed one such taxonomy of key paradigms influencing research in the current era: positivism, post-positivism, critical theory, constructivism, and participatory. They highlighted that there are similarities in beliefs and assumptions particularly in the case of neighboring paradigms, and proposed that “there is great potential for interweaving of viewpoints, for the incorporation of multiple perspectives, and for borrowing, or bricolage, where borrowing seems useful, richness enhancing, or theoretically heuristic” (p.197). In keeping with what Guba and Lincoln (2005) described as the “cautious”
possibility for “blend[ing] elements of one paradigm into another, so that one is engaging in research that represents the best of both world-views” (p. 201), this study leans towards a fluid paradigmatic stance. By this I mean that a constructivist perspective broadly informs the research study, while acknowledging that elements of neighboring paradigms also subtly permeate the inquiry. That is, at times, there is a slight leaning towards one end of the fluid stance more than the other, which may become increasingly evident upon considering how data analysis (e.g., application of grounded theory procedures), reflexivity (how the researcher is and/or is not explicitly incorporated into the process of inquiry), and representation of the findings (e.g., use of different forms) have been approached.

It is also important to note here that constructivism is an umbrella term under which several paradigmatic and theoretical strands can be identified. As such, within the umbrella of constructivism, I include and align with social constructivism and social constructionism. Noteworthy to mention here is the semantic slippage that can be observed in the literature in relation to these two terms, which may be explained, in part, by the subtle distinctions between them. Sparkes and Smith (2006) provide a useful heuristic distinction in relation to these two terms, which I adopt here. Social constructivism places attention on the inter-subjective, micro-psychosocial processes through the inner world of the participant, whereas social constructionism emphasizes consideration of the influence of social and cultural factors, language, and discourse on human behavior. Both perspectives informed the present inquiry, with each of them taking precedence at different points throughout the research process. In the following passages, I elaborate further on the ideas and assumptions commonly associated with the broader perspective of constructivism.

**An overview of constructivism**

I draw my understanding of paradigms and paradigmatic positioning largely from Guba & Lincoln (1994; 2005). Ontologically, constructivism is focused on the nature of social reality. In this stance, social reality is considered to be a construction of mental, social, and experiential activity which is context dependent. The emphasis on context implies a relativist position on the nature of social reality where multiple realities (e.g., multiple experiences, meanings, perspectives) around a particular phenomenon co-exist, while recognizing that certain universals
may also exist across individuals and cross-contextually. Epistemologically, constructivism assumes a subjectivist position on what is knowable; thus, knowledge is a product that is co-constructed through interactions and transactions between the researcher and the subject under inquiry. Methodologically, social constructivism engages both hermeneutic and dialectical processes. Within the context of the present study, the hermeneutic process refers to eliciting and describing multiple perspectives of the phenomenon in question. This is followed by a dialectic engagement with these perspectives whereby they are compared and contrasted for the purpose of arriving at fewer constructions of the phenomenon (e.g., obtained through identification of patterns or via consensus). From an axiological perspective, constructivism assumes that there is inherent value in the transactional process of knowledge creation (Guba & Lincoln, 1994; 2005).

Making the case for constructivist and constructionist perspectives in resilience research. In the previous chapter, I described how constructivist and constructionist perspectives have facilitated a deeper and comprehensive understanding about resilience through being responsive to individuals’ subjectivities and their contexts. Such perspectives can facilitate conducting research which is meaningful to individuals participating in a study, and are well aligned with emerging strengths-based perspectives in mental health service delivery. Engaging the perspectives of marginalized populations can help to better understand what constitutes risk, health, well-being, adversity in different contexts and settings, and the variability and complexity of how resilience manifests across cultures and contexts (Ungar, 2004).

Enacting a constructivist stance and navigating the tensions therein

Applying the ontological perspective of constructivism implies that the ‘findings’ reported in the present study are not considered as representations of a singular truth or only version of the manifested resilience. Given that the findings have been constructed in a situated context, it is acknowledged that others might have elicited different data and produced an alternate version of findings, which may coalesce as well as diverge with what is presented here. Moreover, I duly recognize that findings have not been ‘found’ or ‘discovered’ but rather, have been inter-

---

20 Here, I’m referring to context in a broad way, inclusive of geography (at the urban city level in which the present study takes place), culture (which may refer to the culture of health care provision, for example), services (e.g., mental health, housing and support), and clinical population (e.g., youth recently diagnosed with psychosis).
subjectively constructed, and interpretively created through a process of inquiry that I have played a key role in “orchestrat[ing] and facilitate[ing],” albeit through systematic engagement with participants and their accounts (Guba & Lincoln, 1994, p. 114). From an axiological perspective related to ethics, it is of high value to me that young people have the opportunity to be meaningfully engaged in research that is ultimately meant to inform and improve services for them; as such, the actual process of the research, which includes my interactions with young people, was as important to me as the outcomes of it. This is consistent with the inherent value that constructivists perceive in the transactional process of knowledge creation. My values, for example, influenced decisions pertaining to the research design, particularly around data collection and representation. Choosing to use multiple methods for data collection, for example, was a decision influenced by factors extending beyond the rationale of methodological triangulation (i.e., arriving at the same points through multiple data sources). The use of multiple methods was also intended to contribute a more complex understanding of resilience. Moreover, I felt it was important to offer young people choice around media through which they could engage in the study, and that meaningful participation in research is inherently valuable.

I have also become aware that the enactment of a constructivist axiological stance can be constrained by the cultural conditions of an academic research environment. Upon entering the research field, for example, I found my research axiology coming up against, or in tension with, the health and rehabilitation sciences culture in which I was learning to become a scholar. Surrounding me were louder discourses pertaining to the quantitative notions of objectivity, reliability, validity, and the extent to which findings can be generalized. These criteria which seep their way into being transposed onto qualitative research, do not necessarily correspond with the intentions and process of research conducted using a constructivist stance.

Scholars have raised concerns regarding a preoccupation with the technical execution of methods within the context of legitimizing qualitative research (e.g., see Aguinaldo, 2004; Chamberlain, 2000). “Methodolatry” (p. 285) as Chamberlain refers to it, has engendered an overshadowing of other critical aspects of the research. For me, this legitimization of qualitative research translated into the tangible technicalities of ‘doing’ qualitative research, through mantras such as:
Keep your recorder on
At all times during the interview
Record as much as you can
Transcribe your transcripts in their entirety
Transcribe everything, if you can
Keep a record of this and that, better yet, keep an audit trail
Keep track of all your data,
As your memory cannot prevail
Use qualitative software! To keep the data intact
Check your transcripts
With respondents
Check, check, check again your facts,
Do member checks in fact,
Saturate those findings
And, don’t forget to Publish That

The technical ‘doing’ of qualitative research can take up space in the researcher’s day to day activities constraining room for developing reflexivity throughout the process of inquiry. While I assume the ultimate responsibility for constructing the process of the present inquiry, in retrospect, my sense is that positivist/post-positivist discourses surrounding the research journey, did at times constrain the possibilities for nourishing space in which relational and reflexive actions could occur, that would ultimately be more consistently aligned with an enactment of a constructivist stance. When others provoked my reflections on the embodied nature of the inquiry; encouraged me to pay attention to the actions surrounding the text; and to write myself through and into the process of inquiry, this was helpful in working from a constructivist perspective. These types of encouragements represented for me what Guba and Lincoln (1994) refer to as “resocialization” of novices from the dominant “received view of science” (p. 115).
An overview of symbolic interactionism

Symbolic interactionism focuses on individuals’ meanings to understand their actions and behaviours. This approach is well aligned with the purpose of this inquiry, which is to understand the meanings, experiences, and processes of resilience through the subjective positions of young people recently diagnosed with psychosis. Moreover, the theoretical roots of both grounded theory and narrative inquiry can be traced back to the thinking of American philosophers, psychologists, and sociologists such as George Hebert Mead, William James, John Dewey, and Charles Horton Cooley, which has been critical to the development of symbolic interactionism (Blumer, 1969; Serpe & Stryker, 2011). This further supports the rationale for choosing an interactionist frame in relation to the grounded theory and narrative inquiry methodologies drawn from for the present study.

Core principles of the symbolic interactionist perspective provide a framework through which meaning-making and its relation to action can be understood. Herbert Blumer (1969) is credited as the person who coined the term symbolic interactionism, and described it as both a perspective and an approach to inquiry. Herbert Blumer was influenced by the work of American pragmatists such as George Herbert Mead and John Dewey. The perspectives of these pragmatists shaped the development of three major premises of symbolic interactionism that Blumer (1969) articulated: 1) the meaning that individuals hold for objects (physical, social, and abstract), determines their actions toward these objects. For example, the meaning that a young person attributes to being diagnosed with psychosis, will influence how he/she responds to it; 2) individuals generate meaning for objects during their interaction with others. Thus, meaning is a socially constructed phenomenon. Using the previous example, the meaning a young person attributes to being diagnosed with psychosis is generated through his/her interaction with formal and informal supports as well as the community; and 3) individuals continuously interpret their situations, and these interpretations influence action. Continuing the same example, a young person’s interpretation of psychosis within the context of his/her life is subject to change over time. Symbolic interactionists construe humans as meaning-making agents, which in turn influences how they act in their world. Symbolic interactionism emphasizes a naturalistic approach that engages directly with the empirical world and focuses on understanding human interaction and behavior through meaning. Within the context of symbolic interactionism, Fine
(1992) has emphasized the importance of recognizing that individuals’ agency, that is their self-initiated efforts and actions, is limited by the structures and settings in which they are situated. Applied in the present study, this means that young people’s efforts, and the role the environment plays in influencing the success of their efforts, are dually considered. This approaches what is referred to in the literature as a synthetic form of interactionism (e.g., see Fine, 1992), which seeks to synthesize and incorporate a dual focus on agency and structure into the inquiry, as opposed to excluding one for the other.

Section 2: Making the Case for a Combined Methodological Framework

The present study adopts a combined methodological framework that draws from the principles and methods of grounded theory (Charmaz, 2006; Glaser & Strauss, 1967) and narrative inquiry (Chase, 2005; Riessman, 2008; Sparkes & Smith, 2008). It is important to provide insight into the decision-making processes for choosing such a combined approach. In brief, my rationale for combining the methods of grounded theory and narrative inquiry was to facilitate the elicitation and representation of a more complete and contextualized illustration of the meanings, experiences, and processes of resilience in youth recently diagnosed with psychosis. However, before embarking on such an endeavor, it was necessary to become familiar with the historical, epistemological, and theoretical knowledge of the traditions from which I was proposing to draw methods from. This then enabled me to examine the coherence of the combined approach I was proposing to undertake.

In this section, I provide an overview of grounded theory and narrative inquiry, using a framework encompassing 12 features: history, purpose, theoretical influences, paradigmatic considerations, researcher-phenomenon/process/participant relationships, sampling, data collection, data analysis, representation of findings, and critiques. In doing so, I also explain the commensurability between these two approaches, why they might be combined in a study, and what might be some of the issues associated with combining these two approaches. This is an important undertaking, as the increased trend towards combining methods from various qualitative traditions has not been matched with methodological guidance and discussion on the coherence of such approaches.
An emerging trend

Qualitative researchers are increasingly combining methods, principles, and processes from different methodologies in the course of a research study as opposed to operating strictly within a delineated qualitative tradition. Several researchers, for example, have combined the methods of grounded theory and narrative inquiry (e.g., Bailey & Jackson, 2003, 2005; Cohn et al. 2009; Drew, 2007; Floersch, Longhofer, Kranke, & Townsend, 2010; Macnaughton, 2008).

Researchers who combine methods might do so at some or all stages of the research process, including data collection, data analysis, and representation of findings. In health-related research in particular, this combined approach is often invoked under the pragmatic rationale of producing research that is better positioned to translate into practical domains (e.g., Seaton, 2005).

The combination of methods from different methodologies has been variously labeled: qualitative mixed method design (Morse, 2010), multiple methodology (Seaton, 2005), non-categorical method of research (Thorne, Reimer Kirkham, & O’Flynn-Magee, 2004), interpretive description (Thorne et al., 2004), generic qualitative research (Caelli, Ray, & Mill, 2003), and combined qualitative methodology (Swanson-Kauffman, 1986). While some researchers use these terms interchangeably, others (e.g., Morse, 2010) propose distinctions by applying particular meanings and practices to them. The term combined methodological approach is preferred here to bring attention to the historical, theoretical, and philosophical roots of methodologies from which researchers combine methods. While there is slippage in the literature between the use of the terms method and methodology, I believe the distinction between the two is an important one. Denzin (2010) states, “each qualitative method rests on different assumptions” (p. 422). Methodology can be situated at the interface between paradigm and method; it consists of a set of “skills, assumptions, and practices that the researcher employs as he or she moves from paradigm to the empirical world” (Denzin & Lincoln, 2005, p. 25). Among the most recognized qualitative methodologies are: phenomenology, ethnography, grounded theory, and narrative inquiry. Examples of methods developed within these traditions include: bracketing, participant observation, constant comparative analysis, and narrative interviewing, respectively. When authors refer to the term grounded theory as a method, attention is taken away from the historical, philosophical, theoretical, and methodological aspects that are associated with qualitative traditions such as grounded theory.
Cautionary considerations

Critics caution that combined approaches can be problematic when limited attention is given to key considerations of the constituent methodologies. Caelli et al. (2003) observe that studies utilizing combined approaches are at times poorly anchored within an identifiable epistemological or theoretical perspective. They argue that under the pressure of time constraints, researchers turn toward the “less demanding option” (p. 2) of applying a combined approach because it is perceived as a way to avoid having to fully learn about any one established qualitative tradition. Moreover, those working from a purist paradigmatic and methodological perspective might not see, or agree with, the possibility for compatibility between, and combination of, qualitative traditions such as grounded theory and narrative inquiry. This might especially be the case if they understand these traditions to originate from two diverging paradigms (i.e., grounded theory in post-positivism and narrative inquiry in social constructivism, social constructionism, and postmodernism). It should not also be “naïvely presumed” (Denzin, 2010, p. 422) that combining methods from different methodologies will automatically produce a richer understanding of the phenomenon under study.

Rather than discounting the possibilities of combining based on the aforementioned considerations, it is important to further examine the existing trend of methodological mixing. I concur with Seaton (2005) who suggests that there is a need for “further dialogue and debate regarding the commensurability of interpretive methodologies, and their underlying epistemologies and philosophies, in multiple-methodology research” (p. 192). In response to this proposition, three issues in relation to taking a combined methodological approach, as it pertains to grounded theory and narrative inquiry, and in relation to the present study, are discussed here. First, there is the issue of paradigmatic positioning. Guba and Lincoln (2005) contend that combining methods is acceptable, particularly in cases where methods are derived from methodologies situated within the same or commensurable paradigms. In a related manner, Carter and Little (2007) assert the importance of maintaining a “coherent epistemological position” (p. 1326) in studies that combine methods. Applied to the present study, these assertions suggest the importance of considering paradigmatic compatibility when combining the methods of grounded theory and narrative inquiry. For example, applying an “objectivist” version of grounded theory in combination with the principles and processes of a constructionist
approach to narrative inquiry might raise concerns regarding a study’s internal coherence. Coherency can be better assessed if researchers adopting a combined approach reflexively document their paradigmatic stance as there is a tendency to gloss over this feature of the research design in research reports; in previous sections of this chapter, I have offered an illustration of such reflexive documentation.

Second, to my knowledge, no systematic investigation of studies that combine grounded theory and narrative inquiry (let alone from other methodological traditions) has been made; whereas these philosophical, methodological, and pragmatic issues have been systematically examined where quantitative-qualitative mixed methods research is concerned (e.g., Bryman, 2006). As such, several questions regarding studies that combine the methods, principles, and processes of grounded theory with narrative inquiry remain unexamined, including: philosophical and theoretical underpinnings of such studies; purposes and rationales that researchers have for drawing from these two methodologies; how integration of methods, processes, and principles from these two methodologies occurs during the data collection, analysis, and representation stages of the research; the limitations and challenges presented to researchers in these integrated methodological contexts; and the kinds of outcomes gained by combined methodological approaches.

Third, there are practical considerations to combining methodologies that need to be considered, such as the skill level or expertise of the researcher across methodologies (Morse & Chung, 2003; Seaton, 2005). It is important for researchers to be well versed in approaches that are being combined to avoid pitfalls in research design and application. My experience in conducting and/or contributing to qualitative research projects external to the present study has helped in this regard. At the same time, I took seriously the task of learning about the two traditions of grounded theory and narrative inquiry prior to undertaking the study.

I propose that the integrity of combined approaches can be placed on a continuum of integration. At the ideal end of the spectrum, the researcher demonstrates thorough knowledge of the approaches being combined, thoughtful consideration of the rationale for combining methods, and a heuristic for how the methods will be combined. In a related manner, Aguinaldo (2004) highlights the importance of making explicit the rationales for transcending what Chamberlain (2000) refers to as the “methodological straightjacket” (p. 289). In part, this necessitates a comparative understanding of the constituent methodologies that are being
combined. Although there are instances in the literature in which comparisons of different qualitative traditions can be found (e.g., Creswell, 2007; Starks & Trinidad, 2007), these have been written with the objective of helping the reader to choose one qualitative methodology for a study over another, as opposed to combining methodologies. In the following passages, I provide an overview of grounded theory and narrative inquiry while also conducting a comparative analysis between the two to determine their commensurability and the merits of combining their methods.

Comparing grounded theory and narrative inquiry on 12 methodological features

**Historical development and methodological purpose.** Grounded theory is commonly recognized as a methodology that helps researchers understand psychological and social processes. It offers guidelines for the development of concepts and theories to understand human action and interaction (Charmaz, 2006; Glaser & Strauss, 1967; Strauss & Corbin, 1990). Barney Glaser and Anselm Strauss are credited as the original developers of grounded theory, marked by their landmark textbook, *The Discovery of Grounded Theory* (1967). Their approach offered a way through which theory could be generated by systematic collection and analysis of data within a substantive area of interest. Glaser and Strauss differed from each other in terms of their paradigmatic backgrounds, rendering their collaboration uncharacteristic of the research era in which they were situated. Strauss, an established qualitative sociologist, was highly influenced by the Chicago School of Sociology and symbolic interactionism; Glaser had a quantitative background in descriptive statistics.

Narrative inquiry is a *subtype* of methodology within qualitative research (Chase, 2005) and included alongside other qualitative genres such as ethnography, phenomenology, and grounded theory (Creswell, 2007). Narrative inquiry is most often employed for the purpose of understanding human experience(s). Narratives offer a portal through which experiences can be viewed, interpreted, and then re-presented using storied forms (Bruner, 1991; Chase, 2005; Clandinin, 2006; Riessman, 2008). Thus, the stories that people tell are the vehicles through which experiences are studied. This form of inquiry is based largely on the assumption that stories are a form of social action and the telling of stories is one way that humans experience
life (Bruner, 1991; Chase, 2005; Clandinin, 2006; Riessman, 2008). As such, storytelling is considered to be “negotiated, nonlinear, and interactional” (Mello, 2002, p. 233).

Within narrative inquiry, the purpose is further delineated to focusing on how the narrative is presented in addition to what the narrative content conveys (Smith & Sparkes, 2006). Although it is commonly assumed that grounded theory is the best methodological choice for developing theories about psychological and social processes, narrative inquiry has also been used to theorize psychosocial processes. Frank’s (1995) work, for example, theorizes the psychosocial processes through which people tell stories about their illness, and identifies what effects these ways of telling stories have on their overall experience of illness.

Riessman (2008) describes narrative inquiry as an interdisciplinary approach that is informed through the “humanities, arts and social sciences” (p.16). Because of these interdisciplinary roots, the lineage of narrative inquiry is more challenging to trace when compared to grounded theory; a few key historical moments are referenced here. The interpretation of narratives can be traced as far back as 335 B.C. when Aristotle produced Poetics, which explored the purpose and structure of drama and poetry (Aristotle, 2008). It evolved through the early centuries A.D. within the discipline of theology and the practice of exegesis—interpretation of sacred texts and the development of hermeneutics. Narrative inquiry, in the form of life histories, first appeared in the work of researchers from the Chicago School of Sociology in the early part of the 20th century, where sociologists considered the content of stories told as direct representations of life experiences (Chase, 2005). The 1960s marked a significant turn in researchers’ perspectives and treatment of narratives. Within an emerging discourse on the construction of social reality, other types of inquiry questions began to emerge. Researchers interrogated the stories of narrators, inquiring “how” stories are told (e.g., use of language), for “whom” stories are told, how interviewers influence what stories are told and how they are told, and “why” stories are told (e.g., intentions of the narrator; Riessman, 2008). In the 1980s and early 1990’s, Ricoeur (1988), Bruner (1987, 1991), and Polkinghorne (1988) provided key theoretical, philosophical, and historical contributions on narrative (inquiry). For example, Ricoeur produced numerous accounts on a range of topics relevant to the theory and study of narrative including hermeneutics, time, language, identity, discourse, and action. Bruner (1991) developed a theoretical framework of narrative, detailing its associated features. Polkinghorne (1988) supported the thesis that narrative is a way through which “human beings give meaning to
their experience of temporality and personal actions” (p. 11). Since the 1990s, increased attention in the literature has been placed on the methodological and pedagogic aspects of narrative inquiry (e.g., Clandinin, Pushor, & Orr, 2007; Connelly & Clandinin, 1990; Mishler, 1995; Riessman, 2008).

Drawing on empirical research, several influential works exist which support the importance of narrative inquiry and its development as a methodology within health-related fields of practice and research. In this context, narratives are perceived as vehicles through which illness experiences (Frank, 1995; Kleinman, 1988) and critical turning points in life (McAdams, Reynolds, Lewis, Patten, & Bowman, 2001) can be understood. In medical anthropology, Kleinman (1988) expanded on the meaning of illness using patient narratives. The application of narrative approaches in the context of research on resilience has also increasingly emerged (e.g., see Bottrell, 2007; Hauser & Allen, 2006). These and other works have led to the understanding that narratives are important tools that humans use to make sense of biographical disruptions related to illness and other challenging life circumstances (Bury, 2001; Riessman, 2008).

**Theoretical perspectives bridging grounded theory and narrative inquiry.** The theoretical roots of grounded theory and narrative inquiry can both be traced to American pragmatism. The perspectives of American pragmatists such as George Herbert Mead and John Dewey have been critical to the development of symbolic interactionism, which is the theoretical approach more commonly associated with grounded theory, and which has been previously described in this chapter. Similarly, American pragmatists also had a profound influence on the development of narrative inquiry. Connelly and Clandinin (2006) drew from the Deweyan theory of experience (Dewey, 1938) when they proposed a three dimensional framework for narrative inquiry that is bounded by “temporality, sociality, and place” (p. 479). Dewey’s (1938) theory of experience highlighted two features: interaction and continuity. Dewey postulated that the interactions that individuals have with their social context influence their experience and that past experiences affect future experiences. Blumer (1969) also acknowledged Dewey’s perspective on the role of interaction and temporality on experience as a key component upon which he developed the theoretical perspective and methodological approach of symbolic interactionism.
In addition to the Deweyan theory of experience, the development and application of narrative inquiry has also been influenced by narrative theory, for example through the work of Bruner (1987; 1991). Bruner (1987) classified human thinking (ways of knowing) in two main ways, through the narrative mode and the paradigmatic-positivistic mode. The narrative mode perceives and constructs reality through stories, whereas the paradigmatic mode relies on logical and inductive reasoning. The narrative mode of thinking and the narrative use of language are inextricably linked (Bruner, 1987). There are several features of narrative that are utilized by humans to construct social reality, these include: the narrative organization of events, the storied nature of reality, and the storied form of experience (Bruner, 1991).

Bruner’s narrative theory helps to explain why and in what ways narrative inquirers approach a subject of interest differently than grounded theorists, even those operating within constructivist paradigms. Narrative inquirers believe that humans communicate their experiences using co-constructed narratives that offer an epistemological portal through which experiences can be viewed and interpreted and then re-presented using storied forms. This approach is underpinned by the ontological assumption that humans organize their experiences, memories, life situations, and events in narrative form and as such the nature of reality is at least in part storied. This ontological stance extends the conventional understanding of narrative from being a representation of experience (or some aspect of it) to narrative being a form of experience (Bruner, 1987, 1991). Grounded theorists have historically been more concerned with substantive cross-case theory development than the phenomenological, macro-contextual, performative, and structural understanding of singular narratives.

At the same time, narrative theory can also be conceived of providing a conceptual bridge that strengthens links between narrative inquiry and constructivist applications of grounded theory. Although narrative theory has not been commonly associated with grounded theory, the emphasis in narrative theory on the meaning of symbolic systems that humans use to construct reality, such as language (Bruner, 1987, 1991, 2004) does suggest theoretical commensurability between grounded theory (via symbolic interactionism) and narrative inquiry. Language is the most common form of data collected and analyzed in both narrative inquiry and grounded theory approaches.

**Paradigmatic considerations.** The variety of approaches existing within the narrative inquiry tradition can be partly explained by the range of disciplinary perspectives (e.g.,
humanities-literature studies, psychology, anthropology, and sociology) that have contributed to its development. Differences in approaches across grounded theory and narrative inquiry can also be explained by how researchers position themselves paradigmatically. For example, Hall’s (2011) study on the process through which women survive childhood maltreatment is situated within a constructivist paradigm. In this regard, narratives and the findings therein are perceived to be co-constructed and were thus examined with a focus on understanding the various social elements in the micro-context influencing the co-construction (e.g., the teller, the listener, the intended or implied audience, the research team). A constructionist approach is reflected in Hole’s (2007) narrative research, which asked how deaf women perceive that their identity is shaped by hearing loss and how prevailing discourses of normalcy and deaf culture influence identity formation.

Different approaches to applying grounded theory observed in the literature can partly be explained in relation to paradigmatic positioning. Kathy Charmaz (2006, 2009) dichotomizes grounded theory into two paradigms: objectivist grounded theory and constructivist grounded theory. Using this framework, the works of Glaser and Strauss (1967) and Strauss and Corbin (1990) are labeled as part of the objectivist camp. Charmaz (2006), along with other contemporaries such as Clarke (2003) and Bryant (Bryant & Charmaz, 2007), identify themselves in the constructivist camp.21

The present study is informed by a constructivist application of grounded theory. Grounded theory proponents of this perspective (e.g., Charmaz, 2006) emphasize the importance of multiple perspectives of participants and the researcher; the influence of social structures and processes at micro and macro levels during analyses; and the reflexive role of the researcher throughout the research process. They adopt a subjective “inside” perspective to understanding social situations as opposed to observing neutrally from the outside (Charmaz, 2009, p. 142). It is important to note, however, that there is still an inconsistent or cursory documentation of relational and reflexive processes in the empirical literature wherein authors invoke the use of constructivist grounded theory.

**Researcher-phenomenon, researcher-process, and researcher-participant relationships.** Epistemologically, the relationships that the researcher has with the phenomenon

21 Charmaz (2009) also advocates for the application of grounded theory using social constructionist perspectives
of interest and the research process are treated differently in narrative inquiry when compared to grounded theory. In a narrative inquiry, these relationships are scrutinized as it is argued that to remain “silent or to present a kind of perfect, idealized, inquiring, moralizing self” is a type of self-deception (Clandinin & Connelly, 2000, p. 62). Thus, within the narrative inquiry literature, it is not uncommon for researchers to begin reporting on their studies with an exposition of their relationship to the research (Clandinin & Connelly, 2000). Birmingham’s (2010) article reporting on a study inquiring into the stories of mothers with children diagnosed with autism exemplifies how, in a narrative inquiry, participants’ and researchers’ stories get told and re-told as part of the inquiry. Birmingham begins the article by revealing her relationship with the phenomenon of interest (i.e., being a mother of a child with autism) and told the story of how her academic life and personal life intersected with the conceptualization of the study. The report includes a reflexive examination of the inquiry process, casting light on the role of the researcher and her positioning within the study. In the present study, I have represented this process by weaving my reflexivity throughout the dissertation.

Researcher-participant relationships are a key focus of the narrative inquiry process (e.g., see Clandinin & Connelly, 2000; Riessman, 2008), particularly when compared to grounded theory reference texts. In a narrative inquiry, relational issues are meant to be at the center of every phase of the process, for example, negotiating entry into participants’ lives; discussing consent (not just at the time of recruitment, but more by the way of process consent); relating with participants during data collection; and in relation to the representation of findings. This approach entails ongoing reflections by the researcher on the dialogical process of consent and the participant’s perception of the researcher; in other words, who the researcher is to participants (Clandinin & Connelly, 2000) and why they engage in the researcher’s study. In the present study, for example, for some of the young people, I (and the research study) became a vehicle through which they looked forward to making sense of their illness; for others, I was seen primarily as a potential repository of information on psychosis; for others, I was seen as access to material resource (a gift card); and for others, as an opportunity to contribute to science/knowledge construction.

In contrast, grounded theorists centre discussions on researcher-participant relationships in relation to the outcome of data collection. For example, the relational focus in Charmaz’s (2006) work could be perceived as somewhat technical and instrumental in the sense that the
relationship is mainly conceptualized as a means through which rich data that is, information which is “detailed, focused, and full,” (p. 14) can be obtained. It is important to note, however, that a more constructivist stance that calls for explicit engagement with processes such as reflexivity and participant-researcher relationships has been advocated in the grounded theory literature (Hall & Callery, 2001; Mills, Bonner, & Francis, 2006). These processes call for researchers to “bring to the surface their own histories and thinking…to create a point of referral and interrogation for themselves, and subsequently the reader, in relation to their theoretical analysis. Such a strategy makes the researcher's impact on the reconstruction of meaning into theory clearer” (Mills et al., 2006, p. 11).

**Sampling.** A review of the narrative research literature reveals that a wide range of sample sizes are used, from two (Birmingham, 2010) to 14 (Smith & Sparkes, 2005) to 600 (Labov & Waletzky, 1967/1997). The possibility of prescribing sample size for the research design of a narrative inquiry is complicated by the fact that sample size is predicated on decisions, including: the type of data to be collected; number of participants; duration of researcher-participant relationships; number of contacts with participants; and size of data to be sampled for the analysis. Moreover, the actual number of participants used in a study does not necessarily translate to the quality of findings.

In grounded theory, a key type of sampling that is prescribed is theoretical sampling. The purpose of theoretical sampling is to collect further information on the categories of an emerging theory, and can take place through any of the following: recruiting new participants; returning to the existing sample with focused questions; and collecting new forms of data (Charmaz, 2006; Glaser & Strauss, 1967; Strauss & Corbin, 1990). In this regard, data collection becomes progressively focused with the intention of delineating initial concepts, categories, and relationships (Charmaz, 2006; Glaser & Strauss, 1967). A scan of the grounded theory empirical literature suggests that sample sizes in grounded theory studies typically range from 10-60, which is consistent with observations made by others (e.g., Starks & Trinidad, 2007). However, given the key process of theoretical sampling, it is difficult to prescribe or predict what sample size will be needed in a grounded theory study. Glaser and Strauss (1967) propose that data collection should be guided by the quality of data obtained as opposed to the quantity of individuals recruited.
Data collection and data analysis. In both grounded theory and narrative inquiry, researchers have acknowledged the potential of several data collection methods as sources of evidence (Charmaz, 2006; Glaser & Strauss, 1967; Riessman, 2008). However, in practice, it seems that interviewing, participant observation, and field notes are commonly utilized methods in grounded theory studies (e.g., Backman, Del Fabro Smith, Smith, Montie, & Suto, 2007; Griffith, Caron, Desrosiers, & Thibeault, 2007; Leipert & Reutter, 2005). In contrast, narrative inquiry studies tend to draw from a broader range of data collection methods, including but not exclusive to: elicited written texts from participants (e.g., journals), photography, and other types of artifacts. Moreover, in terms of interviews, narrative inquirers have described the use of the narrative interviewing technique wherein the focus is not only to actively listen for the stories in participants’ accounts, but also to actively engage participants in the telling of stories (Chase, 2005; Riessman, 2008).

The differences in the analytic process involved in grounded theory and narrative inquiry can be explained by what Riessman (2009) refers to as the “category centered” and “case centered” (p. 391) nature of both approaches, respectively. In grounded theory, the focus of analytical procedures is to locate relationships between concepts and themes across interviews through a process of constant comparative analysis (Charmaz, 2006; Glaser & Strauss, 1967). In a narrative inquiry, the researcher strives to locate theory within a participant’s narrative and keep participant stories intact. A story is considered to be a unit of analysis whereas in the grounded theory approach, a story is coded and then fragmented based on one or several categories of emerging interest. A narrative analysis might also consist of coding procedures; however in this case, the researcher codes data by looking for narrative features such as plotlines, details of the setting, characters, and actions within a participant’s account (Clandinin & Connelly, 2000). Hence, narrative inquiry differs analytically from grounded theory particularly in attending to more than just the content of a story. Both constructivist and constructionist approaches consider how events are storied and why events are storied in the way they are. This entails examining various features of communication and social action, including language and style. Only at the final stages of an interpretive process do narrative inquirers embark on a comparative investigation across cases to elucidate differences in experience while considering temporality and context (Chase, 2005; Riessman, 2008).
The guidelines and procedures of grounded theory are often captured within a single reference text (e.g., Charmaz, 2006; Glaser & Strauss, 1967; Strauss & Corbin, 1990), translate easily to research reports, and are an attractive feature when arguing for credibility. The explicit systematic and rigorous procedures developed and documented in grounded theory serve to legitimize its use as a research approach (Thomas & James, 2006). The need for further explication of analytic processes, such as the synthesis offered by Riessman (2008), is particularly important for the narrative inquiry tradition given the range of distinct approaches to analysis developed therein.

**Representation of findings.** Grounded theory studies are commonly published using the conventional formats and linear style of reporting that is typically required of health sciences journals (see Backman et al., 2007 and Reid-Searl, Moxham, Walker, & Happell, 2010). In stark contrast, the forms of representation that narrative inquirers utilize to communicate their findings are much more diverse. Narrative inquirers draw from a variety of disciplines to represent their findings, including but not exclusive to the literary, visual, and performative arts. Although artistic modalities can be effective in promoting audience engagement with research findings, the use of such approaches may also make it difficult for audiences to determine boundaries between researchers and their data and the process of research with the outcomes of research. Upon receiving research findings delivered through performative texts, visual arts, and written stories, it is possible to feel “stranded” with questions about the researchers’ assumptions, intentions, data sources, and analytical processes. This can raise ethical concerns regarding researchers’ responsibilities to the audience in relation to the provision of information about the research process prior to, or immediately after, engaging the audience in a performative/artistic representation of the research findings (e.g., through theatre, dance, or visual or literary arts). In contrast, traditional research reporting provides a template through which answers to these types of questions are addressed at least in part, if not to the full satisfaction of the reader.

**Critiques.** The critiques associated with the narrative inquiry approach are in many respects opposite to those associated with grounded theory methodology. The emphasis on coding procedures in grounded theory and consequent fragmentation of data is associated with the concern of “stripping away” individuals and their experiences in the interest of finding
patterns across cases. Bailey and Jackson (2003) raised this issue of diluting the impact of unique stories in their experience of using grounded theory, writing that “we noticed certain stories leapt off the page — they wanted to be told” (p. 62). Grounded theory methodology has also been critiqued for a tendency to produce simplified representations of complex phenomena as well as to constrain the interpretive aspects of qualitative analysis (Thomas & James, 2006).

In contrast, narrative inquiry approaches have been challenged on the valorization of the personal narrative as a “hyperauthentic version” (Atkinson, 1997, p. 343) of participant experiences and identities. Instead, Atkinson highlights the importance of considering narratives as “modes of performance, of ordering, of remembering, of interaction” (p. 343), which need to be subjected to systematic analysis, as one would do with other forms of data. Moreover, narrative inquiries can be perceived as “overly personal and interpersonal” (Clandinin & Connelly, 2000, p. 181), whereas grounded theory approaches have been perceived as dissecting and diluting participant experiences and contexts (e.g., Bailey & Jackson, 2003; Cohn et al., 2009).

Grounded theory and narrative inquiry have also been the subject of similar critiques. Atkinson (1997) observed that at times narrative inquirers overlook representation of the contextual aspects of personal narratives and how they are constructed. He cited Frank’s (1995) work as an example to support this assertion. The reporting style of grounded theory studies has also been critiqued for de-contextualizing how data are constructed even in constructivist versions (Riessman, 2009).

**Grounded theory and narrative inquiry: Theoretically commensurable, methodologically complementary.** This comparative analysis asserts that grounded theory and narrative inquiry can be combined in a single qualitative study given that they are theoretically commensurable and methodologically complementary. From a theoretical perspective, grounded theory and narrative inquiry are commensurable through roots that coalesce in American pragmatism. Moreover, narrative theory constitutes a bridge between narrative inquiry and the symbolic interaction roots of grounded theory. From a methodological perspective, the comparative analysis of grounded theory and narrative inquiry suggests that leveraging the strengths of narrative inquiry to offset the critiques associated with grounded
theory is a key reason why researchers have chosen to draw from both methodologies in the context of one study.

In particular, researchers invoke the rationale of using narrative inquiry to compensate for concerns regarding the fragmentation of text in grounded theory and consequent loss of participant stories (e.g., Cohn et al., 2009; Drew, 2005, 2007; Herrera, Dahlblom, Dahlgren, & Kullgren, 2006; Schow, 2006). Drew (2005, 2007), for example, combined the analytical procedures of grounded theory with narrative analysis to explore how having a history of childhood cancer influences social and personal well-being in young adulthood. Data analysis involved open coding, axial coding, and then narrative analysis. The combined analytical approach was considered useful for revealing the complex relationship between cancer, identity development, and the ways in which participants story their experiences of surviving cancer.

Researchers also combine the analytical methods of narrative inquiry and grounded theory to enrich understanding of the dynamic nature of core categories that emerge in a grounded theory analysis (e.g., Bailey & Jackson, 2003, 2005; Drew, 2005, 2007; Floersch et al., 2010). It is not uncommon for qualitative health researchers to be interested in individual experiences and processes in relation to a particular phenomenon as well as experiences and processes that are common across a group of participants, as is the case in the present study. This dual concern can be addressed by a combined methodological approach that harnesses the strengths of grounded theory and narrative inquiry.

Researchers also combine grounded theory with the methods of narrative inquiry to communicate findings in ways that are accessible to audiences beyond those who are situated in academia, and which do not “strip” away individual voice and experience. Narrative approaches, which might include a variety of mediums (e.g., visual, literary, performative), can potentially offer a vehicle through which theory can be made accessible to a wider audience, including service providers, service recipients, and family caregivers. Riessman (2009), who has written extensively on narrative inquiry, proposes that unique contributions to knowledge can be provided by studies adopting both grounded theory and narrative inquiry. In her review of Charmaz’s (2006) book, Riessman (2009) concludes by calling attention to the need for methodological examination of how the strengths of grounded theory and narrative inquiry might be maximized within a research design.
Summary and conclusion. This comparative analysis addresses a gap in the literature related to combining methodological approaches in qualitative research, particularly where grounded theory and narrative inquiry are concerned. It can be useful in assisting researchers in their reflection and decision making on choosing a combined methodological approach, developing and articulating rationales for combining methodologies, and ultimately building coherent research designs. Limited knowledge regarding the historical, philosophical, and theoretical background of methodologies from which methods are drawn can lead to misrepresentation and misappropriation of methodologies (and their respective methods) and, consequently, call into question the credibility of combined qualitative methodology research in general. In the case of integrating the methods, principles and processes of grounded theory with narrative inquiry, the analysis shows that these two approaches are theoretically commensurable and can be considered as methodologically complementary. The concerns of fragmentation and de-contextualization in grounded theory can be offset by the “situated and particular” focus associated with narrative inquiry. Moreover, the emphasis on reflexivity and researcher-participant relationships within narrative inquiry can be particularly important for studies that involve ethical and methodological challenges pertaining to doing research (e.g., with marginalized populations). Disparities and differences in power and socio-linguistic and sub-cultural styles between researchers and youth are examples of the types of challenges that benefit from reflexive and relational consideration.

The combined approach helped me to dually privilege individual accounts, as well as identify common elements across participants’ narratives. The explicit, systematic and rigorous analytical procedures developed in grounded theory (Charmaz, 2006) facilitated the development of a cross-case analysis and representation of how resilience is sustained, restored, and enhanced. Narrative inquiry opened up possibilities for developing a richer, contextualized understanding of this process, making findings accessible to a wider range of audience.

Section 3: Setting, Sampling, and Recruitment

The previous sections described the philosophical perspectives and methodological framework that guided the present study. This section provides an overview of the setting in which the study
takes place, particularly in terms of the recruitment sites. It also describes the sampling strategy, recruitment process, and the characteristics of the sample recruited.

**Research setting**

This study took place within a Canadian urban setting. Participants were recruited from two mental health care sites: an early psychosis intervention program (EPIP) and a youth mental health program (YMHP) for street youth. It is important to note here that I did not previously work as a clinician in either of these two sites. My clinical experience with youth recently diagnosed with psychosis pertained to working in programs operating out of a different provincial jurisdiction.

The EPIP provides specialized support, for a period of two to three years, to individuals between the ages of 14-30 recently diagnosed with a psychotic disorder. Assessment, treatment, rehabilitation, and community support are delivered through a multidisciplinary team consisting of psychiatrists, nurses, social workers, and occupational therapists. Each client is assigned to a case manager and is referred to other psychosocial services such as occupational therapy when needed. The program also offers family support and education, as well as group interventions for clients.

The YMHP is a collaborative initiative established between a general hospital and a non-profit organization that provides food and shelter for homeless youth, among other services such as case management, transitional housing, drug and alcohol counseling, and life skills training. Through a partnership between the hospital and non-profit organization, psychiatric and social services are coordinated and delivered to youth presenting with a variety of psychiatric concerns (including psychosis). Psychiatric consultations and mental health services are offered on-site at the youth shelters and single-room occupancy buildings in which youth live (or in nearby coffee shops).

Approval to conduct the study was obtained from research ethics boards operating within three organizations: the University of British Columbia, Providence Health Care and Vancouver.

---

22 There are different types of case management approaches. The non-profit organization adopts the following case management definition: a client-centred process of promoting the coordination of services to facilitate integrated treatment and continuity of care. Case management activities in this regard include: assessments, treatment planning, referrals, case reviews, and discharge planning.
Coastal Health Research Institute. Youth were considered to be vulnerable to potential risks related to participating in this study due to their developmental stage and their mental health status. Thus, ethical concerns related to conducting research with youth and potentially vulnerable or marginalized populations were addressed in the study design (e.g., application of methods recognized as effective in reducing power imbalances between adult researchers and youth participants).

**Sampling**

A purposive sampling strategy was used to recruit 17 youth recently diagnosed with a psychotic disorder and who were recipients of outpatient psychiatric services. By purposive, I mean that recruitment was aimed at obtaining a sample representing diversity in terms of social, cultural, and economic backgrounds. This was achieved by recruiting from the two different settings. The study recruited five females and twelve males, which is in keeping with gender distribution of psychosis incidence rates particularly within the 15-25 year old age group (Amminger, 2006; Garety & Rigg, 2001; A. Malla, personal communication, July 26, 2012).

Inclusion criteria for the study included individuals: 1) receiving outpatient psychiatric services from the EPIP or the YMHP, 2) diagnosed with psychotic disorder within the past three years (schizophrenia, schizoaffective disorder, delusional disorder, brief psychotic disorder, or psychotic disorder NOS, bipolar affective disorder with psychotic symptoms; major depression with psychotic symptoms,\(^3\) 3) between the ages of 16-24, 4) able to speak English, 5) willing to participate, and 6) able to provide informed consent or assent (for participants between the ages of 16-18 living with a parent or legal guardian).\(^4\) Exclusion criteria\(^5\) were individuals that: 1) had no contact with clinical staff more than three months (by telephone or in-person), 2) were

---

\(^3\) Psychiatrists at the YMHP and case managers at the EPIP were asked to identify all clients based on the above-mentioned criteria. I further verified history of psychosis, substance use, hospitalization, and treatments received during initial contact meetings, and asked clients about psychiatric diagnoses they received in the past during initial interviews.

\(^4\) One participant aged 18 was recruited into the study; this participant ran away from foster care at the age of 14, and had since been living independently. For this participant, in accordance with procedures reviewed by ethics, only participant consent was obtained, given his emancipated status with no legal guardian in the picture.

\(^5\) Although it was not an official exclusion criteria at the time of recruitment, all participants that were identified as eligible by clinicians at both sites had been receiving services at those sites for a minimum of three months. Thus, 3 months represented the minimum length of time since diagnoses and/or onset of illness observed in the sample.
currently hospitalized, 3) had a non-psychotic illness, 4) presented with inability to concentrate and attend to conversation, and 5) presented with drug intoxicification at the time of recruitment.

**Recruitment**

The following steps were taken for the purpose of recruitment:

- Visiting the mental health teams at both recruitment sites to describe and discuss the study with clinical staff;
- Providing clinicians with copies of a consent to be contacted form (see Appendix 2) and inviting them to distribute this form to youth who met the study’s inclusion criteria;
- Meeting with individuals who completed the consent to be contacted form or who contacted me directly (via email/telephone) upon hearing about the study. This meeting took place at the recruitment site or at a designated quiet public location depending on the preference of the individual;
- Presenting the study and consent form (see Appendix C) by: fully informing potential participants of the study (purpose of the study, study procedures and participant roles, potential risks and benefits of involvement, interview questions, remuneration/compensation, and confidentiality); avoiding language that contained jargon; and, assuring individuals that participation or non-participation would in no way affect the clinical services they received, and that they could withdraw from the study at any time without penalty. Questions were invited throughout this process and answered accordingly. I also took care to review prospective participants’ understanding of key elements of the consent form;
- Inviting prospective participants to take the consent form home for review for a minimum of 24 hours, and to consider whether they wished to complete the consent process and to participate in the study;
- Obtaining oral and written consent, and providing a copy of the signed form to participants.

One participant, recruited from the YMHP, was 18, and had not lived with a parent or legal guardian since the age of 14. Thus, in this case only informed consent was obtained.

---

26 During the development of the research protocol, I met with clinicians and program leaders at both recruitment sites to discuss the study and to become more familiar with the services they provided. Specifically, I met with two staff at the EP (the program manager and an occupational therapist) and four staff associated with the YMHP (psychiatrist, two social workers, and a clinical leader working at the non-profit organization for street youth).
Characteristics of the sample

A total of 17 individuals were recruited into the study, with a little more than half (59%, n=10) of the sample originating from the EPIP. Table 1 provides details regarding the socio-demographic characteristics of the sample. Information on socio-demographic characteristics was obtained through participant completion of a socio-demographic questionnaire (see Appendix A). This questionnaire asks information in relation to highest level of education achieved, past work history, current school/employment status, living situation, and community/health service utilization. I also asked supplementary questions pertaining to drug and alcohol use, history of psychiatric hospitalizations, and diagnoses. Social-demographic information was managed using Excel software.

In terms of demographics, the age of participants ranged between 18-24, and the majority (n=12) are males. The ethnic backgrounds reflected in the sample are diverse, with seven participants having ethnic cultural-heritages that are other than European (e.g., First Nations, Asian).

In terms of social functioning and status, at the time of recruitment, more than half of the participants lived with family (n=5) or in a single room occupancy building (SRO) (n=5). The rest were living independently (n=2), in a group home for young people with mental illness (n=2), in a shelter (n=2), or with a partner (n=1). The majority (n=12) were unemployed and not involved in educational activities at a high school, college, or university (n=13). None of the participants were married.

In terms of history of illness and health behaviours, the majority (76%, n=13) had a history of at least one psychiatric hospitalization, and of the remaining three participants, two reported psychiatric emergency visits early in their course of help-seeking. Five participants reported ongoing abuse of alcohol and/or drugs.
Table 1

*Socio-demographic characteristics of the sample*

<table>
<thead>
<tr>
<th>Socio-demographic Characteristics</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample Size</td>
<td>17</td>
</tr>
<tr>
<td>EPIP</td>
<td>10</td>
</tr>
<tr>
<td>YMHP</td>
<td>7</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>12</td>
</tr>
<tr>
<td>Female</td>
<td>5</td>
</tr>
<tr>
<td>Mean Age</td>
<td>22  (SD=1.9)</td>
</tr>
<tr>
<td>Ethnic Heritage</td>
<td></td>
</tr>
<tr>
<td>European</td>
<td>10</td>
</tr>
<tr>
<td>Other (e.g., First Nations, Asian)</td>
<td>7</td>
</tr>
<tr>
<td>Household Income</td>
<td></td>
</tr>
<tr>
<td>&lt; $25,000</td>
<td>13</td>
</tr>
<tr>
<td>&gt; $50,000</td>
<td>4</td>
</tr>
<tr>
<td>Highest Level of Education</td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>7</td>
</tr>
<tr>
<td>Completed high school</td>
<td>5</td>
</tr>
<tr>
<td>Some university</td>
<td>4</td>
</tr>
<tr>
<td>Completed bachelor’s degree</td>
<td>1</td>
</tr>
<tr>
<td>Employment Status</td>
<td></td>
</tr>
<tr>
<td>No job</td>
<td>12</td>
</tr>
<tr>
<td>Part time</td>
<td>5</td>
</tr>
<tr>
<td>Full time</td>
<td>0</td>
</tr>
<tr>
<td>Education Status</td>
<td></td>
</tr>
<tr>
<td>Not in School</td>
<td>13</td>
</tr>
<tr>
<td>Part time (university)</td>
<td>3</td>
</tr>
<tr>
<td>Part time (high school GED)</td>
<td>1</td>
</tr>
<tr>
<td>Urban/Suburban</td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>15</td>
</tr>
<tr>
<td>Suburban</td>
<td>2</td>
</tr>
<tr>
<td>Living Situation</td>
<td></td>
</tr>
<tr>
<td>With family</td>
<td>5</td>
</tr>
<tr>
<td>Single Room Occupancy</td>
<td>5</td>
</tr>
<tr>
<td>Independent</td>
<td>2</td>
</tr>
<tr>
<td>Group home</td>
<td>2</td>
</tr>
<tr>
<td>Shelter</td>
<td>2</td>
</tr>
<tr>
<td>With partner</td>
<td>1</td>
</tr>
<tr>
<td>Self-Reported Concerns re: Alcohol and Drug Use</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5</td>
</tr>
<tr>
<td>No</td>
<td>12</td>
</tr>
<tr>
<td>Self-Reported Diagnoses</td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>2</td>
</tr>
<tr>
<td>Schizoaffective</td>
<td>2</td>
</tr>
<tr>
<td>Bipolar Affective with Psychotic Symptoms</td>
<td>4</td>
</tr>
<tr>
<td>Psychosis NOS</td>
<td>9</td>
</tr>
<tr>
<td>History of Psychiatric Hospitalization</td>
<td>13</td>
</tr>
</tbody>
</table>
Comparing participants across the two recruitment sites. There are some remarkable socio-demographic differences between participants who were recruited from the EPIP when compared to those recruited from the YMHP. In relation to social and occupational history and current status, none of the participants from the YMHP have completed a high school education, nor were any of them employed, or participating in prevocational program/activities at the time of recruitment. In contrast, all of the participants from the EPIP have completed high school and the majority (90%, n=9) of these participants were involved in employment, education, or pre-vocational activities such as volunteering or job counselling at the time of recruitment.

All of the participants from the YMHP lived in substandard housing (e.g., SRO building or youth shelter) and described estrangement from their families; whereas the housing situations of participants from the EPIP were more varied (e.g., living with family, living independently, living with a partner, or living in a group home).

In relation to health status and health behaviours all of the participants who reported ongoing substance abuse issues (mainly alcohol, marijuana, and crystal meth) were from the YMHP. Thus, as a group, participants from the YMHP represent a more complex picture in relation to housing situations, education, social supports, employment, and substance use/abuse when compared to the group recruited from the EPIP.

Section 4: Methods

Data collection: Overview of the process and description of the methods

Consistent with the grounded theory approach, data collection and analysis followed an iterative process (Charmaz, 2006), but are described here separately and linearly for the purpose of clarity. The data collection process, illustrated in Figure 1, occurred in three interrelated stages.
Data collection involved narrative interviews (supplemented by participant-created artifacts, such as biographical or literary writing, and visual artworks), and participant-photography elicited focus groups, inspired by the photovoice approach (Wang & Burris, 1997). Data collection also involved collecting social and demographic information using a questionnaire, the purpose of which was to identify variability in the sample and to better understand participant perspectives in relation to socio-demographic factors.

The rationale for adopting a mixed-methods approach to data collection pertained to the following: providing youth with opportunities to “retain some control over the knowledge that is being produced” (Langevang, 2007, p. 270; Punch, 2002; Young & Barrett, 2001); offering them choice in terms of the methods such that they can be more meaningfully engaged in the study; providing different vehicles for communication for those less comfortable with the oral and written word; increasing opportunities for reflection, and engagement with topics that are abstract; reducing disparities in power; bridging socio-linguistic and sub-cultural differences in communication style through the use of photos and various artifacts; and, increasing opportunities for generating various perspectives and understandings.

Figure 1. Overview of the data collection process
Following each contact with participants (either individually or in group), personal reflections were hand written (or audio recorded) and then transcribed. Careful attention was also paid to the memoing process as this is considered to be a major area of weakness of many qualitative research studies (Clarke, 2003). Memo writing allows the researcher to capture reflections about the data, guide data collection, and document findings related to constant comparative analysis of the data (Charmaz, 2006). I started writing memos during Stage I of the data collection process.

I completed two interviews with 14 of the 17 participants. After the completion of two interviews, participants were invited to the photographic component of the study that involved taking pictures of activities, objects, places, and people considered helpful and not so helpful for their well-being. These pictures then served as catalysts for discussion within the context of a focus group meeting with two to three other participants in the study. Over the duration of 1 year, a total of 36 individual interviews were completed (including five member reflection interviews with participants). In addition, three participant-photography elicited focus group discussions were conducted with six individuals from the sample. Thus, some participants were interviewed more than two times across different contexts (e.g., individual interview, participant-photography elicited focus group, and member reflection interview). All interviews, focus groups, and member reflection interviews were digitally recorded and transcribed verbatim.

**Stage 1: Narrative interviews.** In the first stage of the data collection process, two narrative interviews were conducted with each individual at a time and location that was mutually convenient. Narrative interviews are distinguished from other common forms of interviews used in qualitative research (Corbin & Morse, 2003). The narrative interviewer enters the field with the intention of generating “detailed accounts rather than brief answers or general statements” about the phenomenon of interest (Riessman, 2008, p. 23). He or she can accomplish this by engaging with the participant through reflective listening skills rather than focusing on a structured or detailed interview guide. Using this approach redresses power imbalances between researchers and participants and has been found to enrich findings in general (Riessman, 2008).

---

27 Thus, a second interview was not completed with three out of the seventeen participants. The reasons for this are: two of the participants had been evicted from their homes and lost contact with their service providers during the course of the study; consequently, I lost contact with them as well. I was unable to complete a second interview with an additional participant due to scheduling conflicts.
Corbin and Morse (2003) emphasize the importance of skill in conducting a narrative interview; my previous therapeutic experience with this population, and reflective listening skills in general (e.g., I have received training and supervision in motivational interviewing which emphasizes collaborative spirit and reflective listening), provided a foundation from which I could draw upon to conduct the interviews.

Based on participants’ preferences, interviews took place either at the recruitment sites, at designated quiet public locations, or at participants’ homes. The first interview had the intention of establishing rapport and becoming familiar with the background, daily life, illness history, and socio-economic circumstances of the participant. The option of engaging in a “visual ‘action’ activity” (Young & Barrett, 2001, p. 144) was offered to increase opportunities for communication. Such options included creating a mind map related to activity engagement and well-being, and a visual map of one’s supportive networks. These mind maps were then used as launching pads for discussion. The focus of the second interview was to progressively understand the experiences of participants as they related to resilience. Participants were invited to speak about the meaning of well-being, the various challenges they encountered which hindered their well-being, how they have responded to these challenges, and the barriers and facilitators in this regard. Table 2 provides an overview of the questions and probes that guided the interviews. Throughout the data collection process, young people were invited to share visual, internet based, and/or literary artifacts that represented activities, places, people, or objects they found helpful and not so helpful in promoting their well-being and these were subsequently used as catalysts for discussion.

Each interview lasted between 45 minutes to two hours, and on average was 90 minutes including ‘stretch’ breaks. I listened to first interviews and audio coded them, before meeting with participants a second time. The purpose of this strategy was to enable modification of interview style, format, methods, and questions as needed. Consequently, subsequent interviews were increasingly aligned with emergent concepts and categories identified during the preliminary stages of analysis; this is a process that is consistent with the grounded theory approach (Charmaz, 2006).
### Table 2

*Interview guiding questions and probes*

<table>
<thead>
<tr>
<th>Subject Area</th>
<th>Questions and probes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background</strong></td>
<td>• Tell me a little bit about yourself (Probe: activities you like to do, where you grew up).</td>
</tr>
<tr>
<td></td>
<td>• Tell me about a typical weekday/weekend (Probe: the places you spend time in, how you spend time in these places, with whom).</td>
</tr>
<tr>
<td><strong>Environment</strong> (Services, Supports, School, Employment, Other)</td>
<td>• Tell me about your living situation (Probe: family, neighborhood)</td>
</tr>
<tr>
<td></td>
<td>• What types of services do you access in the community? Tell me about your experiences of these services.</td>
</tr>
<tr>
<td></td>
<td>• What have been your experiences of the EPIP (or the YMHP)? What has been helpful, and not so helpful?</td>
</tr>
<tr>
<td></td>
<td>• Tell me about your experiences at school (or work, or home/homeless, other context). What has been helpful, and not so helpful?</td>
</tr>
<tr>
<td></td>
<td>• What do you find helpful in terms of the supports and services you receive?</td>
</tr>
<tr>
<td><strong>Adversities/Risks; Challenges and Responses/Coping; Resources/Strengths</strong></td>
<td>• Tell me about the challenges you have experienced lately.</td>
</tr>
<tr>
<td></td>
<td>• Tell me about how you have been dealing with these concerns in helpful and not so helpful ways.</td>
</tr>
<tr>
<td></td>
<td>• Where do you draw your strength and support from in dealing with these challenges?</td>
</tr>
<tr>
<td></td>
<td>• Thinking about all the ways that people have helped you (are helping you) to make things better, what stands out as being helpful/meaningful, or not so good?</td>
</tr>
<tr>
<td></td>
<td>• Tell me about somebody that stands out for you as a role model in terms of how to deal with challenges in life.</td>
</tr>
<tr>
<td></td>
<td>• Thinking about the ways you have helped yourself to make things better, what stands out as being helpful and not so helpful?</td>
</tr>
<tr>
<td></td>
<td>• How do you know you are doing well?</td>
</tr>
<tr>
<td></td>
<td>• What are the ways that help or can help you be well?</td>
</tr>
</tbody>
</table>
Subject Area | Questions and probes
--- | ---
Other | • What advice would you give to other young people who have gone through similar experiences to you that could help them?
• What would you say to others (such as service providers and families) about how to best help young people who have gone through similar experiences as you?
• Is there anything else you would like to add to this discussion?
• What else would you like to add to this discussion?

**Stage 2: Participant-photography elicited focus groups.** Upon completion of two interviews, participants were invited to the second stage of the study which involved participant-photography elicited focus groups. This method of data collection was inspired by the photovoice approach (Wang & Burris, 1997). Photovoice is a participatory action research approach combining photography and group work to give people an opportunity to record and reflect on their daily lives. Photovoice involves: providing participants with cameras and directions to take pictures based on a research topic; bringing participants together in a group to describe the pictures; and, facilitating group discussion regarding the broader meanings and ideas represented in the pictures. The photos, accompanied by short narratives, are then disseminated through various mechanisms (e.g., through a photo exhibit or video website). This form of representation challenges an academic and professional culture largely built upon the predominant practice of legitimizing knowledge through the oral and written word (Mathison, 2008).

Since its inception in 1997, photovoice has gained much popularity and appeal with researchers working within a variety of disciplines including, but not exclusive to, education, public health, community development, nursing, and social work. A detailed description of the method and an up-to-date synthesis on the extent, range, and nature of how photovoice has been used in health research is documented in a scoping review that I conducted in collaboration with co-authors (Lal, Jarus, & Suto, 2012). In the next section, I highlight results and conclusions from this scoping review that are particularly pertinent to the design of the present study.

*An overview of a scoping review on photovoice.* A total of 191 studies documenting the use of photovoice either as the main research method or in combination with other qualitative or
quantitative methods were identified by the review, the majority of which were published in the last five years. Photovoice was used for several purposes, including to: understand the daily lives and experiences of individuals with disabilities; identify environmental barriers and facilitators to participation in the community; illuminate strategies and processes employed to maintain health and well-being; gain insight into individuals’ experiences of services; and to empower individuals in the process of reflecting upon, and expressing important aspects related to their daily lives. Any of these purposes are relevant to conducting client-centred health and rehabilitation research. We did not identify any studies documenting the use of photovoice with young people recently diagnosed with psychosis, however, 12 of the 191 studies were conducted with individuals experiencing mental illness and addictions, and a significant proportion (24%) of the studies had been conducted with youth.

Photovoice helps to address ethical and methodological issues associated with conducting research with youth (and marginalized populations), such as: reducing pressures of verbal interaction through the intermediary of a prop; and, facilitating reflection and articulation of complex phenomena through the process of visual storytelling (Drew et al., 2010). Photos can serve as an alternative to verbal and written methods, providing participants with other means of self-expression and, thereby, increasing opportunities to engage in the research process (Levin et al., 2007). There is also an element of fun experienced by youth who participate in photovoice studies, and the process has anecdotally been observed to promote a sense of agency and self-efficacy in youth (Molestane et al., 2007).

Although photovoice has wide-ranging appeal as a research method, the ethical and methodological issues associated with using this method with populations experiencing illness and disability warrant further attention in the literature. For example, there are psychosocial issues, such as stigma, to consider when conducting photovoice with individuals who are experiencing illness and disability. Walsh, Hewson, Shier, and Morales (2008) provide an excellent and extensive discussion of the intersection between ethics, stigma, and photovoice. In their study with youth living in a socio-economically vulnerable community affected by unemployment, poverty, and crime, they encountered several stigma-related issues associated with conducting photovoice. The authors raised concerns of whether the project, by way of singling out a particular community, contributed to stigmatization already associated with or experienced by the community. The researchers addressed the issue by ensuring that youth took
pictures that represented balanced perspectives of their community. In another photovoice study conducted by Capous-Desyllas (2010), on the needs and perspectives of women working in the sex industry, one of the participants expressed a high level of concern in relation to the protection of anonymity for fear of stigma repercussions related to people finding out about her work. Thus, while researchers are beginning to explore the potential of photovoice in relation to understanding and addressing social stigma, they are also beginning to encounter ethical considerations of the paradoxical risks that a photovoice project may entail in reifying stigma for a population and community. As stigma is a complex phenomenon, further reflection and examination of this issue is warranted across different populations and settings. Although studies have used photovoice to enhance understanding and awareness on the issue of stigma in relation to different illness and disability conditions (e.g., López, Eng, Randall-David, & Robinson, 2005; Moletsane et al., 2007; Wiersma, 2011), very few have provided focused discussion on the potential risk of re-stigmatisation through participation in this type of method.

**Modified application of photovoice: The present approach.** In the present study, the following steps inspired by the photovoice methodology were taken. Participants were first introduced to the purpose and procedures of the photovoice activity. This was done at the end of second interviews. Next, participants were provided with cameras (unless they wished to use their own), and invited to take pictures on activities, places, objects, and people considered helpful and not so helpful for their well-being. Participants were asked not to take pictures of actual persons nor themselves and the ethical and confidentiality reasons for this directive were discussed. Some participants stayed close to these instructions, while others veered away. For example, one participant opted to take a picture of himself explaining that it was important for him to have his full image displayed, including his facial expression, for conveying his message.

One participant opted to download images from the Internet, even though I offered to provide a disposable camera. Others, while owning a digital camera themselves, opted to submit a combination of images downloaded from the Internet and original images taken by their cameras. During the focus group meeting, participants expressed that in some cases it was easier to find images to convey their meanings from the Internet than to take pictures. The Internet images were used in the same way as the photos during the group discussion, but have not been reproduced in the dissertation due to copyright restrictions.
A total of three participant-photography elicited focus groups were conducted, each lasting the duration of 90 minutes, and each having two or three participants. At the beginning of the group meeting, we discussed group norms as well as issues related to confidentiality. Participants were requested to follow a ‘no-gossip’ rule, whereby topics and information discussed during the group meetings are not to be discussed elsewhere. Each participant then took turns in describing a photo of their choice. During this process, participants were invited to describe the content of the photo (What do we see here in the photo?), the meaning of the photo (How does X relate to your well-being?), and a key message they would like to convey through the photo (What key message would you like to convey with this photo?). A discussion on the themes emerging from the descriptions of the photos ensued. For example, during one focus group, all three participants brought pictures of their pets. This prompted a focused discussion on the meaning of pets in relation to participants’ well-being. During these meetings, I informed participants of general patterns that I had observed in the data through the preliminary stages of analysis (i.e., from previous interviews), particularly if these patterns related to content that had naturally arisen during the group discussion. This enabled the elicitation of a more focused elaboration on emerging concepts and themes.

**Stage 3: Member reflection interviews.** Preliminary findings of the study were discussed with five of the participants in the study. I returned to these participants as they were part of the group of participants that had expressed interest in staying abreast of the project’s process and results well past the first two stages of data collection, and were available to meet during the month that I contacted them. The purpose of these interviews was to elicit reflections and data on the themes developed from the individual interviews they participated in, as well as on common concepts and categories that had been identified across participants in the study; this represented a form of theoretical sampling. Thus, in these meetings, I discussed the various meanings of well-being that had been identified, the emerging focus on the process of normalizing, and the discursive practices such as embracing and distancing identified in the study. To illustrate, in an interview with Kevin, a participant stated that he identified himself as being “pretty embracing,” and that the other categories resonated; in other words, he knew of people who

---

28 Pseudonym
could easily be identified with them. He spontaneously offered further detail on this matter by sharing a story of a young woman he knows that adopts the distancing approach to being labeled with a mental illness. This then led to an illuminating discussion on what possible aspects of Kevin’s life contribute to his adopting an embracing approach of an illness that is otherwise internalized as stigmatizing by so many others (which I will elaborate on in the findings).

**Data management, analytical framework, and representation of findings**

A professional transcriber transcribed the majority of the digital recordings. I transcribed 11% (i.e., n=4) of the interviews, and proofed/checked all transcripts (i.e., while listening to the digital recordings) before entering them into the corpus data set, which was managed by Atlas.ti software. Interviews ranged between 45 minutes to two hours, including breaks, and produced transcripts that were in the range of 25-60 pages. Groups lasted two hours, including breaks, and were also transcribed in their entirety.

Data analysis combined the procedures of grounded theory (Charmaz, 2006; Glaser & Strauss, 1967) and narrative analysis (Riessman, 2008). The analysis involved the following methods: audio coding of first interviews; reading and reviewing all the transcripts; open coding (inductive approach); constant comparative analysis; categorizing lists of codes from interviews; visual mapping of data; coding with attention to narrative themes, structure, and performance; theoretical coding; theoretical sampling; memoing; reflexivity; and, discussions (including sharing key memos) with committee members throughout the process. Details of the process through which these methods were employed are described in the following passages. The analysis proceeded in three overlapping stages, the steps of which are depicted in Figure 2. I kept an audit trail of the process that captures key memos, visual maps, lists of provisional categories, and key turning points during the data analysis.

---

29 Constant comparative analysis involves for example, comparing and contrasting codes (including data pertaining to those codes) within a participant’s dataset; and, comparing and contrasting provisional categories (including data pertaining to those categories) within a participant’s data set to provisional categories from another participant’s data set.
Constant comparative analysis, reflexivity, memoing, and discussion with committee members occurred throughout the three stages.

**Figure 2. Overview of the combined analytical framework**

Consistent with the rigorous analytical principles of grounded theory, data collection and analysis proceeded in an iterative process (Charmaz, 2006). The iterative process enables a cyclical flow from inductively deriving concepts and themes from data observations to then verifying how these concepts and themes are supported or unsupported in relation to other data. During Stage One (Within Case Analysis), I listened to, and conducted open coding of digital recordings of first interviews. M. Suto (co-supervisor) also listened to four of these interviews, which were then discussed by us. This served as a preliminary opportunity to gain a holistic sense of individual experiences and perspectives while keeping close to the actual interview data. Moreover, during this process, I began to document a list of codes (e.g., seeing illness as an opportunity; seeing illness as an interruption/roadblock) that grouped into a provisional set of
categories (e.g., making meaning of illness within the biography one’s life), which informed topical areas to follow up with in second interviews (factors and processes associated with making meaning of illness within the biography of one’s life).

I conducted line-by-line coding of six preliminary interviews, using the Atlas.ti software, which produced code lists in the range of 160-400 per transcript. The purpose of using line-by-line coding at this early stage of the analysis was to minimize a premature analytical focus and premature privileging of theories and interpretations of the data. Segment-by-segment open coding was then systematically applied to all transcripts of first interviews. During this stage, M. Suto also conducted inductive coding of six of the initial interviews and our interpretations were compared, discussed, and folded into the coding process. While coding, I was not only conscious of the what, of the narratives, or the content of the stories; but how stories are told (structural analysis), paying close attention to language; and the relational and performative aspects of the story. This approach was informed by Riessman’s (2008) typology of narrative analysis that captures themes, structure, and performance. Using Excel software, I then made a sheet for each participant with a list of codes from his/her interview, and then grouped these codes into provisional categories. Next, I visually mapped out provisional categories and key themes from each participant using Inspiration software, which was accompanied by a short description of the participant (see Appendix D). I shared and discussed these maps with M. Suto.

Stage Two (Cross-Case Analysis) was focused on identifying patterns across participant accounts. During this stage, I compared the 17 maps of participants, and re-grouped provisional categories across participants resulting in a cumulative and condensed list of 30 categories. The 30 categories were then used for focused coding on the remaining individuals and group interviews. This led to the identification of several potential core categories, which were discussed with committee members. Visual mapping of these core categories as well as memoing and continuous referral back to the data resulted in the identification of normalizing-identity work as the core category around which the analysis would be completed. Theoretical sampling and theoretical coding (conceptualizing relationships between categories) and further memoing resulted in the identification of the sub-variable processes of navigation and engagement in narrative practices and highly valued activities.

As a supplement to this process, and for the purpose of facilitating a contextual focus of the corpus data set, I drew upon Clarke’s (2003) methods of situational analysis as well as Zilber
et al.’s (2008) typology of context. Specifically, I created situational maps and drew relationships between elements of these maps while simultaneously writing memos. Clarke suggests that such tools have the potential of “making the usually invisible and inchoate social features of a situation more visible: all the key elements in the situation and their interrelations; the social worlds and arenas in which the phenomena of interest are embedded; and the discursive positions taken and not taken by actors (human and nonhuman) on key issues” (p. 572). Analysis of each participant’s narrative was guided by the dimensions suggested by Zilber et al. (2008) in relation to a typology of context: the intersubjective field (e.g., communication and understanding between individuals), the social field, and the cultural metanarratives.

During Stage Three (Integration and Representation), results from the first and second stages were integrated into a holistic representation that dually privileges the identification of common elements across participants’ accounts; while at the same time honors their individual and contextualized experiences. As such, in addition to participant quotes, findings are represented through vignettes, which are intended to bring the reader closer to the data, and allow for a more contextualized representation. Moreover, representation of the findings is facilitated through participant-photography and results of visual action activities. In the dissertation, I also convey aspects of researcher reflexivity and the findings through poetic representation.

Pseudonyms have been used in replacement of participants’ real names. Participants were invited to suggest a pseudonym for themselves; where they declined, or did not respond to the invitation, I have provided one for them.

**Section 5: Quality Appraisal**

This section is organized in two parts. First, it begins with a review of the prevailing criteria proposed for the appraisal of qualitative research. This is followed by an identification of a set of proposed criteria adopted from the extant literature for appraisal of the present study, including examples of how the study responds to these criteria.
Navigating the cornucopia of quality appraisal criteria

How can the merits and integrity of a qualitative research study be appraised? Given the range of qualitative methodologies that exist, as well as the various epistemological stances from which qualitative research is applied, the answer is not necessarily as straightforward as one might hope it would be. A cornucopia of qualitative research quality appraisal criteria has emerged over the past two decades. Some of these criteria are specific to methodological traditions. For example, Charmaz (2006) proposes that researchers consider grounded theory studies in relation to credibility, originality, resonance, and usefulness of the findings. Riessman (2008) proposes that narrative inquiries be appraised by aesthetic features and their capacity to evoke emotion in the reader/audience. Moreover, Polkinghorne (2007) suggests the importance of reporting in a manner that makes explicit the steps that were taken to try to reduce the gap between participants’ experienced meanings and the findings presented, which is in alignment with the notion of transparency. Similarities across criteria proposed for quality appraisal of grounded theory and narrative inquiry studies include: credibility, plausibility, trustworthiness, and transparency.

Others have proposed criteria specific to paradigms. For example, Morrow (2005) suggested that Guba and Lincoln’s correspondent criteria of credibility, transferability, dependability, and confirmability are usefully applied within the context of a post-positivist frame, whereas notions of fairness, authenticity, and meaning are more usefully applied within the context of a study conducted within an interpretive-constructivist frame. Still others propose criteria that transcend paradigms (Morrow, 2005, p. 250; Tracy, 2010). In this regard, Tracy (2010) for example, proposed eight criteria: worthiness of the topic, rigor, sincerity, credibility, resonance, contribution, ethical, and coherence.

Scholars argue that it is inappropriate to directly apply notions of reliability, validity, and generalizability, which have been derived within the context of appraising quantitative research, to the qualitative domain of inquiry (Finlay, 2006; Guba & Lincoln, 1994). Instead, researchers have offered different sets of criteria to appraise qualitative research, which either correspond to the quantitative notions aforementioned (e.g., Guba & Lincoln, 1994; Lincoln & Guba, 1985), extend them (e.g., Finlay, 2006), or transcend them (Morrow, 2005; Tracy, 2010). For example, in an effort to offer criteria that correspond to the notions of validity, reliability, and
generalizability, Lincoln and Guba (1985) proposed the criteria of credibility (internal validity), transferability (external validity or generalizability), dependability (reliability) and confirmability (objectivity). While there has been a tradition of applying Lincoln and Guba’s (1985) criteria to appraise qualitative research, these have also been criticized for their limited application to research conducted outside the post-positivist paradigm (Aguinaldo, 2004; Morrow, 2005). Morrow (2005) for example, argued that such criteria were mainly developed in a context of seeking to legitimize qualitative research and appease or translate the nature of this type of work to others, namely those working predominantly from a positivist paradigm, and as such have limited applicability to research that adopts a constructivist stance.

The proliferation of appraisal criteria that have been proposed in the qualitative literature makes it challenging to determine which compiled set will be most useful for any given research study. Complicating matters further in terms of decision making around quality appraisal are studies that combine methodological traditions, and/or which assume fluidity in their paradigmatic positions. Upon navigating the qualitative research quality appraisal criteria terrain, I have come to the conclusion that those criteria which transcend methodological and paradigmatic specificity, in other words, which have features that can be reasonably applied to studies situated across the qualitative paradigmatic and methodological landscape, are most meaningful for the present study.

**Moving towards universal criteria**

Several efforts to propose a set of universal criteria have been made (Ballinger, 2006; Morrow, 2005; Tracy, 2010). Ballinger (2006) proposed four criteria that can be applied to qualitative studies regardless of their epistemological and methodological positions. First, the study can be appraised in terms it its coherence; that is, the links or permeations between its various parts. An epistemological position of constructivism, for example, would need to be manifested in the way findings are represented; reflexivity would be one hallmark considered in this regard. The second and third criteria include whether the research has been conducted systematically and with care; and the extent to which interpretations are convincing and relevant. The specific nature of these criteria will be informed based upon the methodology applied in the study. Fourth, the epistemological position of the research is stated and manifested accordingly in the reporting of
the study. In Table 3, I provide a set of criteria adopted from Ballinger (2006), Morrow (2005), and Tracy (2010) and provide examples of how these criteria are represented in the present study.

Table 3  
**Quality appraisal criteria**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
<th>Examples from the present study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statement of epistemological positioning</td>
<td>Assumptions adopted about the extent to which the phenomenon under inquiry can be understood and how it can become known are explicitly stated.</td>
<td>Epistemological positioning is described at the outset of Chapter 2. Further, I have discussed how epistemological positioning was enacted in the present study, and what types of challenges were experienced in this process.</td>
</tr>
<tr>
<td>(Ballinger, 2006)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coherence</td>
<td>Linkages between various parts of the research design and enacted process.</td>
<td>Coherence can be observed between: 1) the stated research questions and findings, 2) the methodological framework and the way in which data collection and analysis ensued (e.g., coding procedures, and constant comparative analysis were used consistent with grounded theory; the performative aspects of participant accounts were attended to consistent with narrative inquiry, and 3) the methodological framework and the way in which findings are represented (e.g., attention to the situated and particular experiences of participants, as well as patterns across participants).</td>
</tr>
<tr>
<td>(Ballinger, 2006; Tracy, 2010)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sincerity and subjectivity</td>
<td>Reflexivity in terms of researcher’s values, inclinations; transparency in terms of process; and, striving towards fairness of representation.</td>
<td>Reflexivity can be observed throughout the writing, particularly in the methodology and findings chapters, for example through description of the stated paradigmatic stance and discussion of values influencing the inquiry. Transparency can be observed in relation to the detailing of the methodological process, procedures, and examples provided of the analysis; as well as how other committee members were involved. Striving towards fairness of representation can be observed through how</td>
</tr>
<tr>
<td>(Morrow, 2005; Tracy, 2010)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criteria</td>
<td>Description</td>
<td>Examples from the present study</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Rigor</td>
<td><strong>Adequacy of data and interpretation</strong> <em>(Morrow, 2005; Tracy, 2010)</em> Sufficient data collection and time in the field; purposeful sampling; interviews that generate depth and richness in responses; use of multiple data sources; data immersion; articulation of analytical framework; memoing; balancing interpretation with support from the data; and, representation of nuance and complexity.</td>
<td>The researcher was immersed in data collection over a period of one year and thus had prolonged engagement with participants and their accounts; purposeful sampling was achieved through recruitment from two different sites; depth and richness in responses can be observed through the lengthy nature of the interviews and resulting transcripts ranging between 25-60 pages; use of multiple data sources is evident (e.g., photography, individual interviews, focus groups, field notes); memoing was conducted throughout the process; findings are represented through researcher’s summative interpretations, participant quotes, and contextualized accounts of participants.</td>
</tr>
<tr>
<td>Credibility</td>
<td><em>(Tracy, 2010)</em> Trustworthiness and plausibility of the findings; detailed descriptions and explication of tacit, taken for granted knowledge; member reflections; multivocality; triangulation or crystallization.</td>
<td>Details are provided in relation to participant accounts; explication of tacit knowledge can be observed through the unpacking of taken for granted meanings regarding the theme of normality; member reflections were obtained; multiple methods were used for the purpose of crystallization, e.g., to increase a complex understanding of the phenomena.</td>
</tr>
<tr>
<td>Resonance</td>
<td><em>(Tracy, 2010)</em> Evocation (e.g., the text is presented in an evocative and artistic way which encourages the reader to feel, interpret, and react); and, transferability (e.g., readers can transfer the research story to their or others’ situations).</td>
<td>This is left to the reader to decide.</td>
</tr>
</tbody>
</table>
Summary

This chapter provided an overview of the paradigmatic and theoretical perspectives that broadly informed the present study, and also the tensions experienced in enacting a constructivist stance. It presented an argument for undertaking a combined methodological approach wherein the methods from the traditions of grounded theory and narrative inquiry are drawn from. The procedures of the study in terms of sampling, data collection, and analysis were also described. A description of the socio-demographic characteristics of the sample revealed key similarities and differences observed in the sample recruited across the two sites. Finally, the challenges involved in appraising qualitative research were discussed particularly in relation to studies adopting combined approaches. A set of universal criteria were proposed for use in assessing the merits and integrity of the present study, and examples of how these criteria have been addressed in the research design and/or process were provided.
CHAPTER 3: FINDINGS

Synopsis

This chapter presents the findings in detail, through two interrelated sections. The first section (Well-being and the subtext of Normality) captures an important entry point into the present inquiry: The meanings of well-being from the perspectives of young people themselves. The second section (Normalizing-identity work: A core process of sustaining, restoring, and enhancing resilience) explicates the basic psychosocial process of normalizing-identity work in three parts. Part 1 of this second section describes how normalizing-identity work is achieved through the form of narrative practices. The findings suggest that young people employ three types of narrative practices which serve to sustain, restore, and enhance their normal sense of self and identity. These narrative practices include: discursive positioning vis-à-vis the biomedical system of explanation for their psychosis experiences; discursive positioning vis-à-vis being labelled with psychosis (a label which is associated with stigma); and, negotiating the meaning of illness within their biography of life. Part 2 of this second section (Normalizing-identity work through the form of highly valued activities) describes how the process of normalizing-identity work occurs through navigation towards, and engagement in valued activities and interactions. Such activities provide opportunities for sustaining, restoring, and enhancing a normal sense of self and identity through creating-expressing meaning and coherence, calming or energizing the self, connecting with others, contributing to others, and cultivating skills, virtues, and strengths. Part 3 of this second section (Attending to the social, structural, and technological environment) examines how the environment influences young people’s process of normalizing-identity work.
Section 1: Well-being and the Subtext of Normality

Synopsis

This first section describes how young people conceptualize well-being. The findings suggest that young people’s conceptualization of well-being is broad, multidimensional, and incorporates active processes. Moreover, aspects related to young people’s identity are inextricably linked to their meanings of well-being, for example in relation to the notion of normality. To elaborate, the notions of thinking, looking, feeling, and being treated normally are embedded in young people’s experiences of, and desires for enhanced well-being. Experiences of difference and abnormality in relation to their past sense of self, how they compare to others, and how they appear to others, have an important influence on their identity, and form the catalysing conditions in which they embark on the process of normalizing-identity work.

Well-being: Multidimensional, action oriented, and directed towards normality

At this point, it is important to recall that the definition of resilience adopted in the present study incorporates the notion of well-being (i.e., resilience is the capacity of an individual to navigate and negotiate pathways towards well-being in the presence of adversity). Thus, a critical starting point for the inquiry was to understand the meanings of well-being from the perspectives of youth participating in the present study. This was achieved from accounts of young people’s daily lives and also from a more direct inquiry into their understanding of the term; for example, by simply asking: What comes to mind when you hear the word well-being? What does well-being mean for you? The following quotes from participants in this study illustrate the conceptual themes identified across individual responses and accounts:

It means taking care of myself. Getting enough sleep, exercise, social activity, physical activity, just being healthy overall… Going to church I guess makes me more involved, just being involved with other people’s daily lives and learning about them. So I think that’s kind of - it helps your social well-being. (Lily)

30 The term, young people, refers to research participants.
Feeling good about yourself generally. Like getting exercise, feeling energy, having a good mood…well-being is a little broader than health. (Flower)

Become much more spiritual, like, really get in touch with myself and get in touch with my spirits…Become like, very relaxed, at one with myself without any marijuana or any drugs. (Maslow)

Patience is an incredible virtue. It is extremely useful in so many situations in life in order to be happy. (Ross)

The feeling of normalcy. (Jake)

As the above participant quotes illustrate, young people’s conceptualization of well-being is broad, multidimensional, is influenced through action oriented states, and is directed towards experiences of normalcy. In this regard, the meanings of well-being include and extend beyond psychological health by incorporating several dimensions: physical well-being (e.g., getting enough sleep and physical/social activity), social well-being (e.g., feeling comfortable in social situations), psychological well-being (e.g., feeling good about self), emotional well-being (e.g., feeling good; being happy), spiritual well-being (e.g., something to believe in), and moral (virtuous) well-being (e.g., being patient, being honest). Descriptions of well-being involve action oriented states, suggesting the importance of doing or engaging in certain activities in order to experience well-being. Additionally, the social environment (e.g., being judged by people) is a key component of young people’s descriptions, understandings, experiences, and processes of well-being. Table 4 provides further examples derived from participants’ accounts which are heuristically categorized according to different dimensions of well-being that they highlight.
Table 4
The dimensions of well-being

<table>
<thead>
<tr>
<th>The Dimensions of Well-being</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychological Well-being</strong></td>
<td>Being able to concentrate</td>
</tr>
<tr>
<td></td>
<td>Being in control of thoughts and emotions</td>
</tr>
<tr>
<td></td>
<td>Thinking: clearly; positively; not too much</td>
</tr>
<tr>
<td></td>
<td>Feeling of normalcy (in relation to thinking)</td>
</tr>
<tr>
<td></td>
<td>Being and believing in myself; being hopeful</td>
</tr>
<tr>
<td></td>
<td>Feeling good about myself; accepting myself</td>
</tr>
<tr>
<td><strong>Physical Well-being</strong></td>
<td>Being physically active</td>
</tr>
<tr>
<td></td>
<td>Being alert</td>
</tr>
<tr>
<td></td>
<td>Feeling energy</td>
</tr>
<tr>
<td></td>
<td>Eating and sleeping well</td>
</tr>
<tr>
<td></td>
<td>Feeling normal (in relation to embodiment)</td>
</tr>
<tr>
<td><strong>Emotional Well-being</strong></td>
<td>Feeling good</td>
</tr>
<tr>
<td></td>
<td>Being happy</td>
</tr>
<tr>
<td></td>
<td>Experiencing calm</td>
</tr>
<tr>
<td><strong>Moral/Virtuous Well-being</strong></td>
<td>Being respectable</td>
</tr>
<tr>
<td></td>
<td>Doing the right thing</td>
</tr>
<tr>
<td></td>
<td>Doing something good with my time</td>
</tr>
<tr>
<td></td>
<td>Doing something positive with my life</td>
</tr>
<tr>
<td></td>
<td>Being patient</td>
</tr>
<tr>
<td></td>
<td>Being appreciative-having gratitude</td>
</tr>
<tr>
<td></td>
<td>Being autonomous; responsible; mature</td>
</tr>
<tr>
<td><strong>Spiritual Well-being</strong></td>
<td>Being on a spiritual journey of healing body and mind</td>
</tr>
<tr>
<td></td>
<td>Believing in something (e.g., God)</td>
</tr>
<tr>
<td><strong>Social Well-being</strong></td>
<td>Being involved in social activities</td>
</tr>
<tr>
<td></td>
<td>Feeling comfortable in social situations</td>
</tr>
<tr>
<td></td>
<td>Feeling like I'm making sense to others</td>
</tr>
<tr>
<td></td>
<td>Being, feeling, and looking normal</td>
</tr>
</tbody>
</table>
The Dimensions of Well-being

<table>
<thead>
<tr>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doing normal activities, having a normal life, a normal day</td>
</tr>
<tr>
<td>Being treated normally</td>
</tr>
<tr>
<td>Being encouraged</td>
</tr>
<tr>
<td>Being in the right environment (e.g., fit, stability, control)</td>
</tr>
<tr>
<td>Being involved in the community</td>
</tr>
<tr>
<td>Contributing to others’ well-being</td>
</tr>
<tr>
<td>Not being judged</td>
</tr>
<tr>
<td>Performing well</td>
</tr>
</tbody>
</table>

Upon reviewing the contents of Table 4, one can begin to see how elements of young people’s identity are intricately linked to their meanings of well-being. Within this identity context, the subtext31 of normality, for example, thinking, looking, feeling, and being treated normally, is prevalent in young people’s meanings of well-being. Moreover, through the iterative process of data collection and analysis, it became apparent that young people’s use of the term normal and its variants (e.g., normalcy), as well as its antonyms (e.g., abnormal, difference, weird, not normal), provided a lens through which their pathways of resilience could be better understood.

**Normal: Meanings conveyed by young people experiencing early psychosis**

So, it’s a question of what I value right? I guess the feeling of normalcy. (Jake)

What do young people mean when they say “looking normal,” “feeling normal” and being “treated normally?” For example, when Jake states in the quote above that he values the “feeling of normalcy” in relation to his well-being, what does he mean by that? Is he referring to symptoms? Identity? Physical health? A combination of these three factors? Or, is he referring to some other factor/s?

Because the term normal has become a staple of everyday English conversation, one might easily take for granted the meanings a person attempts to convey when invoking this term,

---

31 Subtext (and the adjective subtextual) refers to: “an underlying, often distinct theme in a text, conversation” (Oxford Canadian Dictionary, 2006).
and thus, not even pause to think about it. During the course of this study, however, the use of the term normal (and its derivatives) observed across participants, made me begin to wonder about what participants were endeavouring to convey by using this term.

An inquiry into the meanings of normal from young people’s perspectives indicates that it has symbolic importance for their identities and manifests an important aspect of well-being that they strive to achieve. The experience of normalcy contributes to sustaining, restoring, and enhancing young people’s self-esteem and self-compassion psychosocial resources that have been negatively affected by de-stabilization from cognitive, perceptual, and affective states; deviation from desirable levels of social functioning; and, the stigma of being labelled with a mental illness.

Young people in this study convey six different meanings when making use of the term normal, outlined in Table 5.

<table>
<thead>
<tr>
<th>Emic meanings of normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Typical event/occurrence</td>
</tr>
<tr>
<td>• A point of reference in terms of past behaviours, states, and functioning</td>
</tr>
<tr>
<td>• A strongly valued, personal and social, lived experience intricately linked to well-being</td>
</tr>
<tr>
<td>• Being free from psychiatric symptoms</td>
</tr>
<tr>
<td>• Sub-text of identity (e.g., passing for normal)</td>
</tr>
<tr>
<td>• Activities, settings, interactions free from anything having to do with mental illness</td>
</tr>
<tr>
<td>• Not pathological (related to a phenomenon that is considered as being healthy)</td>
</tr>
</tbody>
</table>

At times, they invoke several of the meanings illustrated in Table 5 at different points in the conversation, each time providing a window into their experiences, values, and efforts. I will

---

32 Self-esteem refers to the evaluative aspect of the self pertaining to efficacy (competency, capability) and worth (Gecas & Schwalbe, 1983; Stets & Burke, 2003).
33 According to Neff (2003; Neff & McGehee, 2010) self-compassion is a view of the self that is composed of three key components: 1) “self-kindness, which refers to the ability to treat oneself with care and understanding rather than harsh self-judgment,” 2) “a sense of common humanity, recognizing that imperfection is a shared aspect of the human experience rather than feeling isolated by one’s failures,” (Neff & McGehee, 2010, p. 226) and, 3) taking on a balanced perspective when considering negative aspects of the self.
illustrate these various meanings through several examples from participants, beginning with Jake.

Jake has been attending the EPIP for approximately 6 months. He lives with his partner in the community and is in the process of completing his Bachelor’s degree. First, Jake uses the term normal to refer to a typical occurrence for him and/or others; for example, to facilitate description of events occurring in a recent day, “I normally cook and eat here, I try not to go out as much” or, his schedule of attendance at EPIP, “it’s normally Monday, Wednesday, Friday that I’ve been going.” Jake also uses the term to distinguish his past, from his present in terms of cognitive, perceptual, and affective states; levels of functioning; and behaviours: “I normally go back and party really hard…and drink a lot and smoke pot. But this year, I’m probably going to go and work out of my parents’ basement basically, and probably spend more time with the family.” Jake also uses the term normal to invoke an embodied, and interpersonally related, lived experience that he strongly values and is striving for:

So it’s a question of what I value right? I guess the feeling of normalcy…It’s just like a spot where I’m only taking things in, I’m not over thinking things on my own, I’m not hearing voices and I want to be able to communicate properly and think clearly.

Through Jake’s quote, one can perceive the connection between normal and being free from symptoms.

Normalcy also includes the experience of being perceived normal. Towards this aim, young people were observed to enact strategies such as limiting self-disclosure. Take for example, Flower, who describes how she avoids disclosure to her friends about her psychiatric history in an effort to look normal, “I haven’t told my friends about that, and I think they still see me as normal and I’m fine with that.” Thus, the meanings of normal are intricately linked to the social environment.

Nelson uses the term normal to refer to activities, settings, and interactions, which are free from having anything to do with mental illness. He has been attending the EPIP for 2 years. He recently moved out of a group home dedicated to young people with mental illness and emphatically explains:

The most annoying thing is that everything is for mental health reasons and I just don’t want this. If it’s a film thing, I don’t want it to be just for mentally ill, and just to address stuff like that. I want it to be, just normal, there’s other fun things you get where you
don’t have to address mental illness, and I don’t want to do that, so that’s it…I want to just get into society… I want to do that normal stuff that’s all.

On several occasions, Bill also uses the term normal, mainly to convey the meaning of healthy. Bill has been receiving services from the YMHP for three months. Bill’s use of normal is situated in his efforts to understand his symptomatic experiences, “In the past when I was hearing voices, I had a tough time, because I wasn’t sure if that was normal or not…Like, I wasn’t sure if that’s proper or not… Like, it made me feel like that’s not normal.”

Normal: Experiences of abnormality/difference and their influence on identity

Through their narrative accounts, one can perceive the concerns that young people have regarding experiences of difference and abnormality in relation to their past sense of self, how they compare to others, and how they appear to others. These experiences of difference and abnormality were observed to be attributed to a number of different psychosocial adversities they faced, including: symptoms of psychosis which impose a significant change in physical, affective, spiritual, and psychological experience; a lack of involvement in mainstream recreation, employment, and educational activities; over involvement in psychiatric or mental health related activities; limited social support; the stigmatising effects of being labelled with a mental illness; and, the stigmatizing effects of being segregated with other marginalized individuals in society (e.g., individuals with a history, or ongoing experiences, of homelessness, addiction, and mental illness). While young people express positive perspectives regarding some aspects of the services they received, there is also an undertone of frustration, embarrassment, trauma, shame, and stigma in their stories of hospitalization, help-seeking, and treatment. Participants recount experiences of being restricted in terms of personal freedoms and having limited involvement in decision making processes, contributing to their experience of losing status. For some, such factors are compounded by socio-economic circumstances such as unstable housing, drug addiction, and limited social support networks. These psychosocial factors are observed to have had a negative influence on young people’s sense of self, as Maslow explains, “the self-esteem--can take a hit.”

Young people, however, do not succumb to this “hit” to their identity; rather they embark upon a process that sustains, restores, and enhances it. Take for example a group discussion,
from one of the participant-photography elicited focus group meetings, between three young people in this study:

Maslow: It’s everything. Low self-esteem, it’s that steam, without it the engine can’t run.
Godess: Yeah, yeah. It pushes you to keep going.
Maslow: Exactly. It’s like, the fire behind-
Lily: Loving yourself!
Godess: To never give up!
Maslow: Regardless of what your income is, or your status is, self-esteem is important. But, when you take individuals like us--who have experienced a psychosis or have a mental illness--we need to kind of be resilient and bounce back...So now, once we’re back into real life, building up that self-esteem and that courage and confidence is crucial to life for the future...It’s because we’ve taken a hit, our self-esteem. That you got to learn how to accept yourself and be comfortable with it.

Participants highlight that building up self-esteem and self-compassion, which contributes to their overall sense of self and identity, is a key pathway towards their well-being. But how do they do it? The analysis reveals that this is done through normalizing-identity work which takes place through two interrelated pathways: engagement in narrative practices and highly valued activities, both of which will be detailed in subsequent sections.

A note on the self, identity, and identity work

At this point in the dissertation, it is important to clarify key constructs that have been inductively highlighted through the analysis of the data, namely in relation to the notions of self, identity, and identity work. In doing so, I draw from theoretical literature pertaining to the self and identity that is situated within the traditional (agency) and structural perspectives of symbolic interactionism (e.g., Burke, 1980; Serpe & Stryker, 2011; Stets & Burke, 2003; Stryker & Burke, 2000).

An individual’s self (or self-concept) consists of a set of identities (Burke, 1980). An identity refers to a “set of meanings attached to the self in a social role” which “serves as a

---

34 The spelling is based on how it was conveyed in an email communication from the participant.
35 In grounded theory lexicon, these terms would be referred to as sensitizing concepts.
standard or reference for a person” (Stets & Burke, 2003, p. 137). For example, a student identity refers to what it means to a particular individual to be a student. Identities also refer to the meanings “others attribute to the person” in a given context or situation (Burke, 1980, p. 18).

Meanings in relation to identities are constructed through interactions with others. Thus, meanings come to be known through symbolic interaction, that is, through the form of shared language (Stets & Burke, 2003). The aforementioned pluralistic perspective on identity implies that the self is multifaceted. An individual has multiple selves that are enacted within the various groups, relationships, and networks he/she forms a part of (James, 1890; as cited in Serpe & Stryker, 2011; Stets & Burke, 2003; Stryker & Burke, 2000).

Burke (1980) describes several other key dimensions of identity including: reflexivity, relationality, and motivation. Reflexivity refers to individuals’ process of assessing their behaviours in relation to their identities. Relationality refers to the relationships within an individual’s set of identities; which for example, could exist through a hierarchy of importance. The last dimension refers to how identities provide the motivation for, or determine social behaviour.

Identity theory postulates that an individual’s ultimate homeostatic aim is to enact an identity that is congruent with environmentally-based appraisals of the self in relation to one’s identity standard (Burke, 1991; Stets & Burke, 2003). Thus taking up this theory, and also drawing on the work of Snow and Anderson (1987), identity work is here defined as the process through which individuals sustain, restore, enhance, and present congruency between environmentally-based appraisals of their enacted selves in relation to their identity standards (subjectively desired identities) through a range of activities.

**Summary**

Thus far, I have explained that psychosis and related psychosocial factors result in young people experiencing difference and abnormality in relation to their past sense of self, how they compare to others, and how they appear to others. These experiences have an important negative influence on their identity and ultimately their well-being. This sets the stage upon which they respond through *resilience-sustaining, restoring, and enhancing identity work*. The process is considered to be resilience oriented because it enables them to strive towards and experience well-being.
through the sustainment, restoration, and enhancement of psychosocial resources (e.g., sense of self and identity). Figure 3 provides a figurative overview of this process and will be further elaborated upon in subsequent sections.

![Diagram](image)

**Figure 3.** Conditions that catalyze normalizing-identity work

### Section 2: Normalizing-Identity Work: A Core Process of Sustaining, Restoring, and Enhancing Resilience

**Synopsis**

This section of the findings chapter introduces and explicates the psychosocial process of normalizing-identity work. Normalizing-identity involves young people navigating and negotiating two interrelated pathways: engagement in narrative practices, and highly valued
activities and interactions. Ultimately, this process serves the pragmatic function of sustaining, restoring, and enhancing a normal sense of self and identity.

This section is presented in three parts. Parts 1 and 2 describe the core forms through which normalizing-identity work occurs: narrative practices, followed by highly valued activities. Part 3 presents an analysis of the ways in which the environment supports and/or hinders young people’s normalizing-identity work.

**Part 1: Normalizing-identity work through the form of narrative practices**

The findings suggest that one key way in which identity work occurs is through the form of narrative practices. Narrative practices serve the pragmatic functions of sustaining, restoring, and enhancing a normal sense of self and identity. Narrative practices collectively refer to the stories that people tell about their lives, the resources they use to tell those stories (e.g., discourses), and the conditions that constrain or facilitate the telling of those stories (Holstein & Gubrium, 2008). I identified three types of narrative practices that show how young people position themselves in relation to psychosis, the biomedical knowledge they receive about psychosis, and how they construct meaning about their experiences of psychosis in relation to their biography of life in ways that appear to normalize their sense of self and identity. Each of these narrative practices is associated with several strategies, listed in Table 6.
Three types of narrative practices and associated strategies

<table>
<thead>
<tr>
<th>Discursive Positioning Vis-à-Vis Being Labelled with Psychosis</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Distancing</td>
<td>Disassociating self from the label of psychosis (mental illness) and/or individuals and settings associated with it</td>
</tr>
<tr>
<td>Reducing over-identification</td>
<td>Reducing possibilities of being constrained and encapsulated by illness identity, while explicitly acknowledging and accepting being given a label of psychosis (mental illness)</td>
</tr>
<tr>
<td>Embracing-crusading</td>
<td>Openly identifying association with the label of psychosis (mental illness) along with individuals and settings associated with it; and, undertaking a remedial enterprise of correcting negative social attitudes about mental illness</td>
</tr>
<tr>
<td>Abstaining</td>
<td>Enacting a neutral stance and/or abstaining from expressing a position on the issue of being labelled with psychosis (mental illness)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discursive Positioning Vis-À-Vis the Biomedical System of Explanation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Substituting</td>
<td>Emphasising an alternative system of explanation for becoming unwell</td>
</tr>
<tr>
<td>Aligning</td>
<td>Agreeing/accepting the biomedical system of explanation for experiences of psychosis</td>
</tr>
<tr>
<td>Supplementing</td>
<td>Agreeing with the biomedical system of explanation for experiences of psychosis, while simultaneously emphasising existence of additional explanations</td>
</tr>
<tr>
<td>Seeking</td>
<td>Striving to better understand the biomedical system of explanation for experiences of psychosis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Making Meaning of Illness Within The Biography of One’s Life</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Consequence</td>
<td>Perceiving illness as a result of past behaviours (e.g., lifestyle management)</td>
</tr>
<tr>
<td>Interruption</td>
<td>Perceiving illness as an interruption (obstacle, roadblock) within the course of one’s life journey</td>
</tr>
<tr>
<td>Opportunity</td>
<td>Perceiving illness as providing an opportunity for personal growth and/or access to resources considered meaningful for well-being</td>
</tr>
<tr>
<td>Unknown</td>
<td>Striving to better understand the meaning of illness in relation to one’s life</td>
</tr>
</tbody>
</table>
First, there is the narrative practice of discursive positioning vis-à-vis being labelled with psychosis. Here young people respond in different ways to being identified as a member of a stigmatized group in society. In this regard, four types of discursive positioning strategies are employed: *distancing*, *reducing over-identification* (in other words, resisting engulfment), *embracing-crusading*, and *abstaining*.

Second, there is the narrative practice of discursive positioning vis-à-vis the biomedical system of explanation\(^{36}\) for psychosis. This biomedical system of explanation is made available to youth largely through their interactions with service providers. Youth receiving services from the EPIP tend to be more familiar with, and able to discursively engage with a biomedical system of explanation, even if they do not explicitly agree with it, whereas this system of explanation is less present in the accounts of youth from the YMHP. In fact, some of these latter participants make active efforts to use conversations with me as a venue through which to access more information on the biomedical system of explanation (or any system of explanation for that matter) for their experiences of psychosis. Thus, across participants, different discursive positioning strategies vis-à-vis the biomedical system of explanation were observed, these include: *substituting*, *aligning*, *supplementing*, and *seeking*. Third, there is the narrative practice of constructing the meaning of illness within the biography of one’s life. This meaning of illness is constructed through viewing it as a *consequence*, *interruption*, *opportunity*, and *unknown*.

To illustrate these three types of narrative practices in the context of youth’s identity work, elements from the accounts of six young people will be used as exemplars. In each participant’s account, I will demonstrate their use of strategies pertaining to the three narrative practice types. However, before going further, it is important to note here that each of these narrative practices and their associated discursive strategies are not necessarily staged to represent any particular order, nor configuration. The extent to which young people vary their strategies across contexts is not a question that I can conclusively address with the data obtained given my interactions with them were limited to the research interview context. However, I did notice that participants generally maintained their discursive stances across individual and group formats. Moreover, I cannot reasonably interpret the evolution in the enactment of these strategies across time. However, through their retrospective accounts, there is some evidence to

---

\(^{36}\) Here I adopt Larsen’s (2004) term “system of explanation.” He defines it as: “a *generalized* explanatory framework, in contrast to illness narrative or explanatory model, which refer to *specific* stories or discourses narrated by specific individuals placed in time and space” (p. 457).
suggest that the types of discursive strategies that young people employ are not necessarily constant over time. For example, the retrospective accounts of some participants indicate that when they first encountered treatment services for psychosis, they employed distancing strategies, but as time progressed, some shifted to aligning strategies while others shifted to embracing ones. These discursive transitions had implications on their engagement with services and in their illness management more broadly. This shift in the use of different narrative strategies is described further in Section 2, where findings are discussed in relation to catalyst activities and interactions (e.g., hearing the stories of others in the context of psychosocial intervention groups) young people identify as being critical in influencing a change in their responses to being labelled with psychosis.

**Distancing, substituting, and viewing illness as consequence.** Flower lives with her family, in a well-established, upper-class Canadian neighbourhood. She has been receiving services from the EPIP for approximately 6 months following a psychiatric hospitalization which she describes as being traumatising. Outside of attending the EPIP, Flower spends most of her time at home, university, yoga studio, gym, and other public and entertainment venues. Being diagnosed with a psychotic disorder is a highly stigmatizing experience for Flower impacting her sense of self and identity. To illustrate, at the end of my first meeting with Flower, she discloses the stigmatizing impact of being labelled with having a mental illness, “It’s a little bit of a hard hit. . .to be called that.” Indeed, even uttering these words comes to me as a leap of self-disclosure within our interaction. In a second interview, Flower elaborates further by stating, “I don’t like the word [chuckles].” I inquire further, “Which word are you talking about?” and she responds, “Um, like, a few people told me that I’m psychotic or have psychosis so… It makes me feel like, um, it makes me feel like I went crazy or something…” In an effort to reflect her distancing stance, as opposed to injecting an alternative perspective into our conversation, I ask her how she manages with this “thing called psychosis,” to which she responds, “Well I haven’t told anyone- my friends about that, and I think they still see me as normal, and I’m fine with that.”

Flower’s narrative practices, which includes how she uses language, how she tells her story, and the discourses that she draws from to construct her story in relation to psychosis, are captured by the following narrative strategies: distancing, substituting, and perceiving illness as a
consequence within the biography of her life. She distances herself from being labeled with psychosis through language avoidance and/or substitution, for example, by using the term “that” to refer to psychosis; as such, it is as if, to vocalize such words would permanently etch a stigmatizing label onto her identity. This is further evidenced by her silences, hesitancies, and verbal substitutions around psychiatric terms such as psychosis and psychotic episode. Through these strategies, Flower sets the stage for how we discursively dance throughout the duration of the study, with her leading the way; in other words, our interactions are plotted through her narrative practices. To elaborate, I too, like Flower, become hesitant in using psychiatric terms, particularly in relation to her personal life; instead, I take Flower’s lead by using language that serves to objectify and distance the label of psychosis from her, for example, by referring to psychosis, as “this thing called psychosis” as opposed to “your experiences of psychosis.”

Health care professionals in the EPIP provide Flower with a biomedical explanation of the experiences leading to her psychiatric hospitalization. Members of Flower’s family support this biomedical explanatory model. However, Flower substitutes the biomedical explanation with another, one that is oriented towards lifestyle management and the environment. She explains that being away from a stable home environment, the stress of school, and engaging in irregular sleeping and eating patterns are the causes of her becoming “unwell.” She attributes feeling better over time to her efforts at eating, sleeping, exercising, and also to being in the comfort of her family’s home. Although her family “thought that [she] was a little paranoid,” she counter-proposes that she “was just a little stressed out.” Thus, within the overall biography of Flower’s life, the meaning of illness is centered upon, and constructed as a consequence of lifestyle habits, academic stress, and being away from the comfort of her home. As such, efforts at “getting better” relate to disciplining herself into balanced routines of meaningful activities, sleep, healthy eating, socialization, and exercise. She questions whether taking medication is a necessary part of her strategy towards getting well, and emphasizes that ultimately it was: “not my decision to take medication.” Nonetheless, Flower takes medication on a regular basis, because her “parents give it” to her. Over the period of one year across six separate interactions with Flower, she maintained the above framing of her experiences, while also continuing to be adherent to the medications prescribed to her, which eventually she started taking on her own.

Flower overcomes the adverse experience of stigma by navigating and negotiating discursive strategies, activities, and interactions with others to enhance her sense of self through
the process of normalizing-identity work. The theme of normalizing within the context of Flower’s identity work is illustrated by her substitution of the biomedical explanatory framework with one that is centred on issues that are more typically faced by Canadian youth her age pertaining to lifestyle, the environment, and academic stress. In Flower’s model of health, mental health is influenced by physical health, and thus, lifestyle management is a key strategy towards maintaining her mental health. Consistent with Flower’s discursive strategy of distancing, she spends most of her time in mainstream environments, and away from settings that are explicitly for individuals with mental illness (outside of the EPIP). Moreover, similar to others adopting this strategy, Flower builds conventionality into her day-to-day life, such as going out for lunch or coffee with friends or family members, engaging in social networking activities over the internet, and working out at the gym. She further strives to enact an identity that embodies looking or appearing normal by restricting disclosure to her friends.

Young people, using similar strategies as Flower, distance themselves from aspects related to mental illness and/or anything having to do with it (e.g., individuals, activities, settings). Additionally, they emphasise that their illness is not as bad as others, or make statements that imply they have been wrongly categorized, placed, or labelled. For example, Nelson states that attending a recreational service for young people with mental illness reinforces his sense of being ghettoized and undervalued: “When I’m in there it feels like I’m underrated …it feels like it’s a class for special people, or something that I don’t belong in.” He further compares himself to others attending this service and makes the point that “Some mental illnesses are stronger than others.” In our conversations, he highlights that his personality as an “extraverted intuitive feeling perceptive person” increases the likelihood of being mislabeled. He states, “We’re the most mistaken in our personality of having a mental illness,” information that he has ascertained through reading on the topic. While Nelson takes medication for psychosis and appreciates its benefits for improving his ability to think clearly, he also engages with a system of explanation that substitutes a biomedical one with one that is related to personality. This approach seems to provide him with a sense of hope and normalization as it shifts attention from being a person with a mental illness or psychiatric disorder, to being a person with a certain type of personality, which has strengths and limitations. To summarize, Nelson finds his normal sense of self and identity constrained in his daily life as he spends much of his time in settings specialized for individuals with mental illness; he responds to this predicament by exercising his
narrative freedom in his interactions with others (including me). For example, through discursive distancing from a stigmatizing label, and substituting the biomedical explanation with one that is related to personality, he constructs a more hopeful, normal identity for himself, as opposed to one that is riddled by illness.

It is interesting to note that while the discursive strategies that Nelson and Flower employ seem to be in tension with a biomedical system of explanation for their illness, they nonetheless continue to engage in biomedical illness management strategies (e.g., taking medication). It is in their interactions with others that they enact their agency to foreground one explanation over the other, in ways that suit their desired identities.

**Aligning, reducing over-identification, and viewing illness as interruption.** Jake is living independently in the community and has been receiving services from the EPIP for approximately 6 months. Mental health service providers at EPIP provide Jake with a biomedical explanation for his experiences of psychosis that he appreciates and discursively aligns with. For example, Jake states:

He gave us a presentation on the brain and psychosis, which was informative, a lot of stuff that I’ve heard before, but a lot of new terminology as well, a lot of neuroanatomy...There’s statistics about what psychosis is, and just, you know, useful tidbits...Just how degenerative it can be if it’s untreated...

Further, Jake states that he wishes he “never had schizophrenia;” however, he accepts having received this diagnosis, and in contrast to Flower, openly engages with psychosis related terminology.

Jake emphasizes that his focus and priority in recent months has been “treating the illness.” While he appreciates the mental health services offered to him, Jake also discursively negotiates reducing over-identification with the label of being diagnosed with psychosis and its related consequences. He expresses that he is very much looking forward to the upcoming weeks, when his appointments at the EPIP will become less frequent, and he will spend more time in activities that he experiences as normalizing; such as going to school, potentially working, and engaging in social/recreational activities. This, he says, will provide him with a story that he can tell, that is not riddled with a subtext of illness:
Another big challenge that I have is having a story, like when I do go out and I am with friends… having a story that goes beyond ‘I’ve been diagnosed with schizophrenia, and I’ve been spending all my time with doctors.’

He further anticipates that engagement in what he perceives to be a more normal schedule of activities will ultimately help to alleviate the social awkwardness, anxiety, and withdrawal that he has experienced in recent months.

Jake explains that he is in the process of completing his undergraduate degree but psychosis has been an obstacle in this endeavor. Psychosis is discursively narrated as an interruption within the broader biography of Jake’s life, as he explains it’s like “hitting a roadblock.” Metaphorically, the roadblock pertains to functional performance at school, but also represents a narrative roadblock in terms of being challenged with having a “tellable” story.

Like other young people in this study, Jake employs the narrative strategies of aligning, reducing over-identification, and constructing illness as an interruption in the biography of his life. By aligning I mean that he agrees with the diagnoses he has been provided, to the extent that it represents something that can be addressed with medical treatment. Young people using this strategy invoke psychiatric terminology in a matter of fact manner, and use terms such as “repair,” “fix,” and “treat” when referring to their engagement in illness management activities. In this regard, they approach psychosis, analogical to any other medical illness; this appears to help normalize their experience. Towards this aim, they appreciate receiving prevalence information regarding psychosis, and hearing that others have had similar experiences as themselves. Their interactions with the mental health care system mainly pertain to receiving information, adjusting medication, and receiving tips on coping. Beyond these types of interactions, they strive towards spending the majority of their time in activities, contexts, and interactions that are not related to mental illness, in other words, reducing over-identification (or resisting engulfment) by an illness identity. Even within the context of research related conversations, they strive to reduce a focus on illness. For example, at the end of our first interview, Jake expresses some frustration with regard to how he has responded to my questions. He notices that my questions largely pertain to aspects of his life that are not necessarily related to illness and that he nonetheless tends to focus his answers in relation to illness. He states that he would like to reduce this over-identification with illness in our subsequent interview:
You’re asking me a lot of normal questions about my life and I keep referring back to the illness so I guess next time I should be more ready for that and just sort of answer the questions as they come about and not always relate to the illness.

_Embrazing-crusading, supplementing, and viewing illness as opportunity._ Ken lives in a group home for young people with mental illness and describes having a difficult childhood marked by parental divorce, alcoholism in the family, and a parent passing away when he was growing up. Ken moved out to be on his own at the age of 17. He then went through a period of unstable housing, and was subsequently hospitalized for a manic episode with symptoms of psychosis. In remarkable contrast to the description of his childhood and adolescent experiences, Ken describes his psychiatric hospitalization as being a key positive turning point in his life. Being hospitalized is narratively constructed as an opportunity to get his life back on track and make it better; moreover, it has resulted in changing Ken’s outlook on life, and has strengthened his belief in God. Ultimately, being hospitalized is considered to be a blessing in disguise, as Ken states:

God has given me another chance to turn my life around because that's what I was just asking for… life wasn’t going the right way… I'd be grinding for money, grinding for cash, just grinding to get money to eat so…but here I'm comfortable. Like, I have a good home. I've never had this before, just a steady home, so it's good to have that, and that's why I see it as a blessing.

Ken is speaking about the group home that he lives in. Like some of the other young people in this study, he openly identifies, and even embraces being associated with a group of people affected by mental illness. Like Jake (and unlike Flower and Nelson), Ken uses psychiatric terminology comfortably within our conversations, and is at ease in having candid discussions about mental illness and its relation to his life. Consequently, I too, am at ease in using psychiatric terminology with him.

Unlike Jake, Ken engages in the discursive strategy of supplementing the biomedical explanation for his psychosis experiences with other types of information. This in turn appears to enhance his sense of self and identity. For example, he speaks to the heightened creativity and sensitivity that he has as a result of having bipolar disorder. Compelled by his insights, Ken endeavors to write a book that aims to shift societal discourse on mental illness:
That's what I'm trying to do with my book. Just trying to show people the other side of things. It's based loosely on my life...That's also a big part of my book, shedding new light on schizophrenia, bipolar. Saying that it's not something that kills your life and just takes out all inspiration; you can live with it, you can live a great life with it.

Ken also wishes to help others who have been through similar circumstances as himself by taking a vocational path that will put him in the position of helper, “telling them [clients], where I've come from, and after having this experience, that would be my ideal job...Just helping.”

Ken’s account illustrates how the discursive strategy of embracing-crusading is incorporated into his identity work. It is interesting to note that all of the young people in this study that were observed to employ the embracing-crusading strategy (n=5) also report an affective component to their diagnoses (e.g., either bipolar disorder or schizoaffective). These young people gravitate towards, and explicitly enact enabling discourses about mental illness as opposed to disabling ones. This is a form of normalizing-identity work as it helps to remove the disabled identity that is associated with having a mental illness, and replaces it with an empowered one.

To further illustrate, Maslow also employs the discursive strategies of embracing-crusading, supplementing, and conceiving illness as an opportunity within the biography of his life. Maslow is a young man receiving services from the EPIP. He supplements the biomedical system of explanation with those available to him from his socio-cultural environment. For example, like Ken, he also speaks to the heightened creativity and sensitivity that he has as a result of having bipolar disorder. He cites famous individuals such as John Nash to convey the message that great things have been accomplished by people with mental illness. During his first psychiatric hospitalization, upon being diagnosed with bipolar disorder, Maslow states that nurses provided him with a list of successful, famous individuals diagnosed with bipolar disorder. This event, symbolic of hope and future possibilities, appears to facilitate Maslow’s engagement in narrative practices that ultimately serve to protect, restore, and enhance his identity:

I wasn't even affected when they told me I had bipolar. Like, one of the nurses at the hospital gave me this list of all these people who have bipolar who are extremely successful and it was amazing -- amazing how many names that were recognizable on the list. So, that's cool to think, like, I'm not going to let any label hold me back, you
Young people employing this discursive strategy of embracing-crusading endeavour to shift the limits of societal discourse in terms of what is possible within the context of having a mental illness (and by implication what is possible for themselves). They aim to convey that having a mental illness may not be as negative as it is generally perceived to be. To make this point, some frame it from the perspective that having a mental illness places people at an advantage as opposed to a disadvantage. For example, Maslow refers to this as: The bipolar advantage. In this regard, these young people discursively narrate illness as an opportunity within the biography of their lives. Towards the aim of contributing social understanding and shifting social discourse on mental illness, young people in this study have adopted the task of writing auto-biographical accounts, and/or working towards becoming health care professionals, and/or adopting other helping roles. It seems that participating in this study also became a vehicle through which young people undertook this crusade; in other words, a remedial enterprise of correcting negative social attitudes about mental illness (and ultimately attitudes towards themselves as persons who have been labelled with a mental illness).37

**Abstaining, seeking, and viewing illness as unknown.** Bill moves to Vancouver following a two-year period of untreated psychosis and housing instability. He gains access to a downtown youth shelter where he is offered psychiatric services from the YMHP. Soon after, he is started on antipsychotic medication and three months later, while he is still living in the youth shelter, we have our first interview. Bill explains to me that one of the main reasons he agrees to participate in the study is because he envisions that it will provide him with the opportunity to discuss psychosis, something he has been seeking to learn more about. Bill describes having had limited opportunities to ask questions about his illness and make sense of the bits of information he has acquired and/or been given regarding this matter. His account contrasts significantly with those of young people recruited from the EPIP in this regard. Beyond the availability of weekly psychiatric consultations, Bill states he has not had opportunities to engage in facilitated discussions with other peers experiencing psychosis, nor with other types of health care

---

37 This is further detailed in the subsequent section on engaging in highly valued activities, where participating in the present research for some participants served the well-being enhancing experience of *contribute*. 
professionals, such as clinical case managers. Within the context of our conversations, it is evident that Bill is discursively centered on the process of seeking more information on the biomedical system of explanation he has been given for his experiences. For example, in his interactions with me, he negotiates for information by asking non-rhetorical questions as he reflects upon his experiences:

I don’t know much about it. But they said it could be like psychosis or something…Is it like, someone said, like schizophrenia or something?... I don’t know what that is…What is schizophrenia?… I’m curious to see what it is…Especially if I’m going through it.

Through our interactions, Bill seeks for information and meaning-making opportunities regarding his experiences. With limited knowledge about his illness, Bill discursively abstains or appears neutral to the issue of being labeled with a stigmatizing disorder. Moreover, the way in which the illness is configured within the biography of Bill’s life also remains absent, or at least on the surface seems unknown. Thus, Bill’s narrative practices, fully enacted within the context of our interactions, are cumulatively captured by seeking, abstaining, and conceiving illness as unknown.

**Summary**

In this section, I have illustrated how young people engage in identity work through the form of narrative practices. These narrative practices relate to: being labelled with a mental illness; receiving a biomedical explanation of their experiences; and the meaning of illness in the context of their lives. They respond to being labelled with psychosis either by distancing themselves from the label, embracing it, striving to reduce being over identified with it, or maintaining a more neutral stance while gathering further information on it. They respond to receiving a biomedical system of explanation for their experiences by substituting it with another system of explanation, aligning and agreeing with it, supplementing it with other information, or seeking more information on it. Young people discursively integrate the illness within the broader biography of their lives by either conceiving it as: a consequence to poor choices in lifestyle management, an interruption or obstacle that needs to be addressed, an opportunity in their lives to make things better, or with unknown meaning. The ultimate function of these narrative strategies is to facilitate young people’s normalizing-identity work. Discourses from the
immediate and broader environment, and interactions with others, contribute to shaping and supporting young people’s process of normalizing-identity work.

**Part 2: Normalizing-identity work through the form of highly valued activities**

In addition to narrative practices, the findings suggest that young people’s normalizing-identity work also takes place through the form of highly valued activities. As illustrated in Figure 4, young people sustain, restore, and enhance their identities through activities that facilitate access to five types of well-being enhancing experiences: creating-expressing meaning, calming or energizing, connecting with others, contributing to others, and cultivating skills, virtues, and strengths.

*Figure 4. Five C's: Well-being enhancing experiences derived from engaging in highly valued activities*
Creating-expressing meaning refers to expressing thoughts and emotions in relation to personal life experiences and making sense of those experiences within the biography of one’s life. Calming refers to accessing comfort and relaxation, and/or reducing states of anxiety. Energizing refers to accessing an up-beat, motivated, and energized mood. Connecting with others refers to experiences of belonging through social interaction with acquaintances, families, peers, and other individuals in the community. Contributing to others refers to providing support to other individuals, beings (e.g., animals), or projects (e.g., knowledge construction) through providing informational, emotional, instrumental/practical, and experiential support.

A pattern was noted whereby the highly valued activities identified by young people often served several of the five core well-being enhancing experiences mentioned above, or served as pathways to access those well-being enhancing experiences in the future. These experiences are considered as resilience enhancing as they serve the function of identity work through building the psychosocial resources of a normal sense of self, self-esteem and self-compassion.

To illustrate how engagement in highly valued activities facilitates access to well-being enhancing experiences, excerpts from the accounts of several participants in relation to these activities will be used as exemplars. It is important to note that in presenting the findings, I have selected activities that were commonly raised as being highly valued by at least 3 participants in the study; concurrently, I only provide quotes and examples from one or two participants to illustrate and validate interpretations. The main point that I endeavour to convey through the subsequent passages is that across the varied types of highly valued activities, participants commonly derived similar types of well-being enhancing experiences, namely: creating-expressing meaning, calming or energizing, connecting with others, contributing to others, and cultivating skills, virtues, and strengths.

**Art-making and its role in Flower’s well-being.** Flower is a young woman living with her parents in a well-established, upper class Canadian neighbourhood. She identifies art making as an activity that is highly valuable for her well-being. At our first interview, Flower lays out several pieces of her artwork for me in her living room, seen in Figure 5.
Figure 5. Photograph from Flower: Art making and well-being

I find the process of making art itself quite therapeutic; it helps express my feelings or thoughts which is important for keeping healthy. A few of the art works in particular more relate to general well-being.

Through Flower’s descriptions of her artwork, it becomes clear that she derives the well-being enhancing and therapeutic experiences of creating-expressing meaning, calming or relaxing states, contributing to others, and cultivating skills and strengths through the process of art making. In part this is achieved through focusing art on different aspects of her life. For example, as she explains, “I think the subjects that I use in painting also help with healing.” She describes one of her paintings with a theme that embodies a “spiritual awakening;” in a subsequent meeting, Flower reveals that she has occasionally interpreted the experiences preceding hospitalization as being of a spiritual nature. Thus, the making of, as well as the description of, this painting could be conceived of enactments and re-enactments of self-expression, emotional release, recording, and meaning-making. She states:

---

38 This photo includes a painting that has been cropped to preserve confidentiality of the participant; though it should be noted that in doing so, a key aspect of the content (and aesthetic appeal of the photo) is removed.
Art is a way of expressing myself and it’s a way of healing for me. I find I’m usually calmed by art. Like even if I feel emotional and then I start drawing, I express something on paper, and then it’s taken out of me and put on paper, so it’s there and I remember it but, I don’t have to feel that way anymore because it’s recorded for me.

Flower has been cultivating her artistry through formative learning since high school. She currently does contract work and recently completed a painting for which she received positive feedback. We discuss this painting and the feedback that she has received on it, and it appears that Flower derives a sense of confidence and self-worth through the encouragement and praising responses she receives from others regarding her artistry. Currently, Flower is exploring the possibility of pursuing art-education, and in this regard would follow in the same career path as her role models, which she elaborates upon by stating, “Yes, so then I would continue that process of contributing and influencing the lives of others.”

Flower summarizes the role of art in her life by stating, “Art is my profession.” Yet, art is not only Flower’s profession; it is also her hobby, and a vehicle through which she engages in a healing practice that embodies calming and meaning-making experiences. Flower’s description of the role of art-making in her life illustrates how a highly valued activity permeates through various life domains and becomes a source that facilitates her process of resilience sustainment, restoration, and enhancement.

**Biographical narration and its role in Maslow and Nelson’s well-being.** Maslow has been receiving services from the EPIP for approximately 3 months. He lives with his family in a Canadian upper class neighbourhood. Previous to being hospitalized for the first time, he was attending university. At the end of our first meeting, the purpose of which was to review the consent form, he exclaims: “Of course I’ll participate; this is exactly the thing I’ve been waiting for.” Over the period of one year, Maslow’s enthusiasm for the study continues to infuse our interactions. At the end of our first interview, upon asking if he had any concluding comments to add to the discussion, Maslow tells me that his experience in the interview was different than other occasions he has had to tell his story. He explains:

Well, there are not many opportunities I have to talk about what happened…It feels good to talk with someone who really wants to listen to you. Not just someone that’s just ‘oh, cool, cool’, who’s actually going to record you, and listen to you, and think about what
you said later. It's really special…Like, I'm not talking to you because you're going to diagnose me with pills.

Over the course of our contact, Maslow reiterates to me in different ways that he looks forward to our meetings. During a member reflection interview, following a relapse and hospitalization, Maslow is very much interested in starting the discussion with describing his recent illness experience and dialogically engages in the sense making of it. Although Maslow has never participated in a research study before, his understanding of the research process is notable and it is evident that he derives a sense of self-worth from participating in this study. He expresses appreciation for the fact that I will be “looking for patterns” in his narrative and “how it will compare” to other young people’s experiences. Maslow also expresses interest to meet other participants in the study through the participant-elicited photography focus group meetings. During his attendance at one of these meetings, he makes an active effort to inquire about his peers’ psychosis experiences, as well as offer them support through words of encouragement and hope. Maslow, like other youth in this study, attributes a high level of importance to activities that enable him to: express and make meaning out of his illness and broader life; and, make connections with, and contribute to others’ well-being. In this case, the activity through which Maslow was able to derive several core well-being enhancing experiences was participation in this research study.

Maslow also uses journaling as a way of making sense of his experiences, and also to make a contribution to the research process. This became evident to me in the middle of our second interview, wherein before going out for a smoke break, Maslow spontaneously hands me his journal stating, “Here’s my journal, maybe it can help…” Excerpts from the journal speak largely to his experiences of psychosis. Like Maslow, Nelson also engages in biographical writing outside of the health care setting. Nelson’s account of this activity is more explicitly therapeutic:

Writing really helps; write down my troubles… It definitely does, it just clears my mind. I have a box full of written journals…and I’ll go home today, and I’ll read from the box from things like two years ago, and it would make me laugh all the time… and then I relate it to how’s my life, what to do next. I put a lot of ideas down… I'm always doing that because I think I need therapy; maybe I don't, I should just write.
For Nelson, biographical writing is also normalizing in the sense that he does not engage in this coping activity in ‘therapy,’ but in the comfort of his own home.

*Engaging with music and its role in Godess, Lily, and Ross’ well-being.*

Participants described engaging with music, through various forms of activities, as being very meaningful in relation to their well-being. In the subsequent passages, examples of such activities will be illustrated through three participant accounts: Godess (singing), Lily (listening to music), and Ross (playing a musical instrument). More importantly, these accounts serve as additional examples to support the finding that young people commonly derive the five well-being enhancing experiences (previously described) through engagement in highly valued activities.

Godess is a young woman attending university on a part-time basis towards completion of a Bachelor’s degree in psychology. At our first meeting, Godess identifies singing as a highly valued activity in her life. I invite Godess to explore what role singing plays in her life. Through a mind mapping activity, the graphical result of which is illustrated in Figure 6, Godess explains she has “fun” singing, and it is also an activity that she performs well. For example, when she is taking public transportation (which is described by her as a stressful activity), she occasionally sings, and aside from the occasional “shush,” “most people are like ‘wow, you have a great voice’ and stuff.” Godess’ account provides indication that positive feedback on performance in an activity she enjoys, contributes to enhancing her self-esteem.

Not only does Godess enjoy singing, she also identifies singing as a coping mechanism. It helps distract her from feelings of sadness, negative and/or racing thoughts. She states: “It’s a distracter too like if my thoughts are kind of disorganized and all over the place, or I don’t like what I’m thinking, I’ll just sing to myself and then I feel better, and my mind is clear because all it thinks about is the song.” She concludes that “the melody is calming” and expresses that ultimately, “It just makes me happy.” Within the context of a focus group conversation with other peers on the topic of music, Godess elaborates further on the therapeutic dimensions of engaging in music related activities. In the following quote, she talks about how listening to songs contributes to her wellbeing:
Well someone wrote the song, and sang the song obviously, you know, other people out there are feeling the same way, so you kind of feel a bit better that way, and it helps you to really acknowledge your emotion.

Thus, for Godess, and other young people in the study who speak about the meaning of music in their lives, the opportunity to express oneself through the lyrics of music is releasing and calming; moreover, it enables them to normalize their experiences in terms of not feeling alone in their experiences.

Figure 6. Mindmap from Godess: Singing and well-being

Lily (along with several others) also speaks to the high importance of music in her life and its salubrious value for her. In the picture below (Figure 7), derived from one of the participant photography-elicited focus group meetings, Lily describes her iPod and explains how music is
helpful for her well-being by enabling access to core experiences of calming or energizing (mood enhancing), and creating-expressing meaning:

*Figure 7. Photograph from Lily: Listening to music and well-being*

*I believe that music is important for my well-being because it helps me relax and remain calm when I am under stress or fatigue. Music can also improve my mood because fast music, for example, can keep me active and energized. It can also help me concentrate on the lyrics of the songs and understand how it relates to myself or those around me. I believe that young people can benefit from music because it can improve their mood, helps them focus on the meaning of songs, and can aid in relaxation.*

Ross, a young man who has been receiving services from the EPIP for approximately 1 year and who lives with his family and works part time, identifies playing the guitar as a highly valued activity that promotes his well-being. When he was a child growing up, his dad had several guitars in the house and Ross used to strum on them from time to time. His dad then bought him a guitar at the age of 15 and started teaching him to play, which eventually led Ross to developing his skills more formally through private guitar lessons. When asked about how guitar playing is important for his well-being, Ross explains that it enables him to “exercise” his cognitive and physical strengths and skills, as well as his patience. He explains,
It's a good thing for exercising your finger and brain dexterity, it's a good physical thing, it basically makes you smarter. And exercising patience in order to get better because you have to practice…you have to be patient when you practice.

From Ross’ account we can see the importance of developing mastery for young people; it is not just about playing the guitar, but getting better at it (see Figure 8).

![Guitar Practicing](image)

*Figure 8. Photograph from Ross: Practicing on the guitar and well-being*

I think that's the most important thing, practicing is being patient and doing it slow. The slower you learn it, the better you learn it. It's always like that.

The cultivation of skills, virtues, and strengths are core experiences that other young people in this study also access through activities they identify as being of highly valued for their well-being. For example, Darren and Smiley who live in a youth shelter and SRO building respectively, also cultivate their skills through guitar playing.

One can also see a pattern related to the social dimension of activities young people identify as being highly valuable to their well-being. As Ross explains, guitar playing is not only about cultivating skills, virtues, and strengths; it also enables him to connect with others:
Playing music is just such a great thing for meeting new people. It's a great connector. It always has, it always will be. You're able to meet new people through playing music… you can go more places, you know, see more people. There's just more possibilities when you can play an instrument.

Through this highly valued activity of playing and listening to music, a common activity that young people engage in when they get together, Ross constructs normality in his life. Moreover, similar to Godess who gets positive feedback when she sings in public, playing the guitar in the company of friends contributes to Ross’ self-esteem: “It feels good to impress your friends, playing guitar in front of them, and most of them don't play an instrument. They kind of go, ‘wow, that's just incredible; it's amazing’.”

**Going to work (or volunteering) and its role in Lily, Godess, and Philip's well-being.** Lily is a young woman living with her family and working part time. She works part-time as an assistant in a health related clinic. Lily considers going to work as a highly valued activity for her well-being. In a mind mapping activity (see Figure 9), Lily explains how going to work is important for her well-being. On the far middle left of this figure, and through her verbal descriptions, we can see that one key reason Lily values going to work is that it facilitates her social well-being.
Figure 9. Mindmap from Lily: Going to work and well-being

She states that going to work is “good for well-being because it’s kind of, like connecting with the community. So you’re connecting with others at work.” She explains that through work she gets to meet new people, such as co-workers and customers, have conversations with them, assist the staff, and help customers with problems. Work provides Lily with opportunities to develop social skills, problem solving skills, and ultimately contributes to her self-esteem, as she states, “It makes me feel competent.” Thus, through the cultivation of social and executive functioning skills at work, Lily enhances the self-esteem (including self-confidence) aspects of her identity, within a normalizing context. Illustrated on the right side of Figure 9, when asked if there were
any ways in which going to work was not helpful for her well-being, Lily mentions that going to work takes time away from studying and having to wake up early causes her “sleep deprivation.” Despite these less helpful factors, it is clear that there are several more ways through which Lily perceives value in relation to going to work and her well-being.

Work also contributes to Lily’s well-being by enabling her to help others. Similarly, other young people in this study who spend time volunteering perceive it as being an important activity in relation to their well-being. It provides them with the opportunity to contribute to the well-being of others; in other words, making a contribution to something outside of themselves. For example, they described deriving self-worth, moral status, and happiness from the opportunity to help others either through volunteering, working, or providing peer support. Godess explains the effects of helping others on various dimensions of her well-being (e.g., social, psychological, moral):

By helping others, you help yourself, too…You feel like you have more purpose in life when you’re having an effect on other people. And your self-esteem is improved too. Cause then you feel, like, wow, I actually did something for another person, it really helped them, I must be a good person.

Accordingly, some participants identify the activity of helping others or contributing to others’ well-being as a core component of their career related goals. For example, participants expressed wanting to become a psychologist, educator, dental hygienist, coach, librarian, and a social worker. The value of helping others, and the aspiration to do so, is present in young people across socio-economic circumstances. For example, Philip, who struggles with substance abuse and currently lives in substandard housing, aspires to have opportunities to make a contribution to others. He states, “In the near future I want to go to [Housing Program] and try and convince people of my generation to do positive things with their life.”

Making a contribution to others’ well-being reinforces young people’s normal sense of self. It enables them to shift roles from being ‘the helped’ to ‘the helper,’ which in turn enhances their self-esteem and ultimately their well-being. The meaning of opportunities to provide support and care to others may be amplified for young people in this study as they may feel constrained and even de-valued by the effects of being placed in a position of receiving help for various mental health and social needs. This may be particularly important also from a developmental perspective, given that young people are at the stage of increasing autonomy.
which in the context of illness can be counteracted by formal and informal caregiver efforts that place them in the position of being cared for. Moreover, being kind to others, for example in the context of extending help to someone else, helps young people define and sustain, restore, and enhance their experiences of self-worth and self-compassion. As Flower articulates: “Being kind to others is helpful for my wellbeing because it makes me feel more worthy. More worthy of life.”

**Being with, and taking care of pets, and their role in Michael, Kevin, Flower, and Lily’s well-being.** Michael is a young man living in a SRO building downtown. He receives services from the YMHP. He has been living in unstable housing conditions since the age of 12 when he ran away from his foster home. At our first and only interview, Michael sits down with me for two hours and tells me his life story as well as the current challenges he faces. I meet with Michael only once because I lose contact with him following his eviction from the SRO building that he is living in. Michael describes a typical day as follows: staying most of the time in his room, staring at the wall, and stressed out about how he is going to cope with the paranoid thoughts he experiences when he is outside. When asked about what his ideal day would look like, he states it would involve being able to go outside and having his dog with him: “that would be the day of my life, seeing my dog again.” Michael’s dog is named Phoenix.\(^{39}\) Due to Michael’s deteriorating mental health, a few months ago, he asked his friend’s mother to take care of his dog. When asked about life goals, Michael maintains, “getting my dog back.” Michael explains that having Phoenix in his life has been a key facilitating factor in his ability to reduce substance abuse in the past. Moreover, having the responsibility of taking care of Phoenix enabled him to quit fraudulent activity:

That’s pretty much one reason why I quit fraud, because I didn’t want to go to jail, because I had something important in my life- looking after her. She was like a security blanket…She would try and make me feel better, she helped me. When you’re actually upset, they cuddle up to you and its company.

Similar to Michael, taking care of pets is considered a highly valued activity by other young people in this study, as illustrated in the picture below taken by Kevin (Figure 10). At one of the participant-photography elicited focus group meetings, Kevin states:

\(^{39}\) Phoenix is a pseudonym
Figure 10. Photograph from Kevin: Taking care of pets and well-being

Here’s a picture of my two cats. I think cats are important because they help you get away from human issues and focus on the more simpler kind of problems, like, just having enough food and water and attention. And it helps you to give love to things so that you can receive it later.

Flower and Lily also bring pictures of their pets to the same focus group meeting. Pets provide opportunities to create meaning and value out of their lives. Through the act of contributing to their pets’ well-being and bonding with them, young people experience comfort and calming, and cultivate the virtues of responsibility and love. These core experiences are illustrated through Michael and Kevin’s account above as well as the following quote from Flower:

They're important to me because they provide me with something to care for. Also, adopting them from the SPCA made me feel good because, they wouldn't have had a home otherwise. I find them very calming, and it also helps people know that bonding doesn't necessarily have to be with other human beings; relationships can be built with animals, too.
Listening to psychosis and recovery stories of peers and their role in Kevin, Jake, Lily, and Maslow’s well-being. Up until now, I have identified activities that young people value and engage in within context of their daily lives, outside of treatment settings. However, when I specifically asked young people about the services they received and what aspects of those services they found most helpful for their well-being, a significant number of them referred to their participation in support and education groups. All participants in the study who participated in such groups from the EPIP, a total of 6 out of a possible 10, spoke of this activity as one of the services they valued the most. Analysis across young people’s accounts of their participation in such groups reveals a consistent pattern of accessing the well-being enhancing experiences heretofore mentioned. That is, attending educational and support groups serves as an opportunity for: creating-expressing meaning, calming and comforting self, connecting with others, contributing to others, and cultivating skills, virtues, and strengths.

In fact, attending support and education groups is described as a critical turning point in young’s people’s lives. Young people explain that when they first start receiving services from the EPIP, they do not believe they have an illness, but to avoid family conflict and maintain stability within their housing environment, they adhere to medication and participate in the treatments offered, such as attending groups. Young people express that attending support and education groups enabled them to shift from “denying” the illness to accepting it, as Kevin explains:

The groups were very helpful for getting me to acknowledge that I actually had an illness. Coming face-to-face with some of the symptoms that I was having because I was still in denial when I was going to the groups.

Given that a number of different psychosis related subjects are addressed in these groups, and delivered through different methods (e.g., PowerPoint presentations about psychosis and its treatment, hearing the stories of others, sharing one’s story, learning about stress management, lifestyle enhancement), I wondered, what aspects of these groups are most salient for young people? Further discussion with participants and analysis of the data, indicate that hearing the stories of others, within the context of an education and support group intervention, contributes to young people’s ability to create meaning of their illness, construct an explanatory model of

---

[40] It is also noteworthy to mention that Philip, who receives services from the YMHP, also derives high value from his attendance at “anonymous groups” (i.e., alcoholics anonymous, narcotics anonymous).
their experiences, normalize their experiences, and to envision hopeful futures. In this context, they connect with other peers at a deeper level through experiencing each other’s comfort, and contribute to the well-being of others through offering a supportive presence while a story is shared. This is further detailed in the following passages.

Young people explain that being exposed to others’ stories helps them to actively “define what actually happened” to them. As Jake explains, it helps them to face the experiences they have as symptoms of an illness:

And then you talk to people, who said they’ve heard or seen the same things or thought the same things, and you’re like, okay, well, I’m definitely suffering from symptoms here. And then you can start getting more involved with what’s the medication, and they provide the information that you need.

Another example of the impact of listening to the stories of others on young people’s well-being is offered through Lily’s account. Lily adopts the discursive strategy of aligning to the biomedical system of explanation for her experiences; however, initially this was not the case. For example, she states that when she was first diagnosed, she didn’t believe she had symptoms of psychosis, and didn’t follow medical advice that was provided to her. She was reluctant to take medication and continued to have conflicts at home. Thus, Lily was at that time, as participants describe, in “denial” of the illness.

Lily then explains that she subsequently began to attend groups at the EPIP and perceives this as being one of the most helpful health related services she has received (in addition to being prescribed medication for her symptoms). These groups were pivotal from a normalizing perspective, in that they helped her come to the realization that she was not alone in her experiences, as Lily explains: “the group shares… and it helps ‘cause you hear other people have the same problem as you, and you don't feel alone.” In this group, she is just like everybody else.

Similarly, when I ask Maslow about his experiences of the EPIP, the groups are the first topic he raises:

It’s been great, they have, like a first intro to psychosis group, it's every Thursday at, I think, 3:00 - 5:00…There'd be five or six other guys there. They'd show us a video. We'd talk about certain topics. They'd have food there. It was really comforting not only getting informed, but feeling the comfort of other people who experienced what you

---

41 Brief quote from Flower
experienced is amazing. Like, before the meetings and after the meetings talking to them. I'm still friends with them now. We still work out and do things together now. It was really nice.

One can see how Maslow first describes the group in a matter of fact way, and then arrives at a “but” in his sentence that prefaces his statement that being in the presence of others who have experienced what he has is “amazing.” He elaborates in another interview that,

It adds to the support for resiliency; just to hear that other people are dealing with it, too. And you just realize it, and you look them in the eyes, you shake their hand and it’s all good, you know—You’re not just the only one. That’s pretty important.

Maslow’s interactions with his peers are experienced as calming and comforting, and through this connectivity he has built bonds with them outside the clinical context.

Supporting this process of treatment engagement and illness management is the presence of peers who represent successful models for recovery. When I ask Jake about role models in his life, he immediately responds by describing a peer support worker who attends the groups at the EPIP. He tells me that this worker is diagnosed with schizophrenia, and is in the process of completing her university degree. She is employed by the regional mental health system in which he receives services. As his account unfolds, the critical impact that the personal story of this peer support worker has on him in terms of instilling hope for the possibility of a normal life after being diagnosed with schizophrenia is conveyed:

She’s just a cool person; sort of explained the challenges she went through, explained the hearing voices part, and explained that with the right combination of medications or professional help, which we were getting, you could actually treat the symptoms and live a normal life. And she seemed really unaffected by her symptoms, so having her around was like, ‘okay, maybe this does go away’...She was definitely a good role model to see that you could recover from it, or at least present to other people that you weren’t suffering from it.

The last sentence in Jake’s quote is another example of the prevalent subtextual theme in young people’s accounts, that is, the integral, interactive, social dimension of normality (i.e., looking normal).
Summary

This second section has explained how young people navigate and negotiate the process of resilience enhancing identity work through engagement in highly valued activities and interactions. Highly valued activities identified by young people typically provide access to one or several of the following core experiences: creating-expressing meaning, calming or energizing, connecting, contributing, and cultivating. These experiences in turn, influence the process of identity work through contributing positively to self-esteem, self-compassion, and a normal sense of self and identity. In addition, highly valued activities tend to concurrently serve multiple well-being enhancing experiences. Finally, the interrelationship between engagement in highly valued activities and narrative practices has also been highlighted in the latter part of this second section. Next, I shift the lens over to understanding the environmental role in young people’s process of resilience.

Part 3: Attending to the technological, social, and structural environment

    Synopsis. Up till now, I have focussed attention on young people’s processes of resilience, particularly in relation to their engagement in narrative practices and highly valued activities. Young people’s accounts also illustrate how their success in this process is influenced by the environment. In this third and final section of the findings, I attend more closely to the contextual aspects of young people’s lives, particularly in relation to the technological, social, and structural environment.

    Technological environment.
Flower posts her art on the Internet,  
Kevin is on MSN,  
Nelson posts his profile on a Dating Site,  
They’re on Facebook with Friends.  
Darren posts Videos playing the Guitar,  
Michael demonstrates on iPad while Standing at his Door.  
Smiley lives in an SRO, she just got a Phone to Go,  
Nelson has lots of Cool Gadgets to Show.  
He plays Online with his brother Kane,  
Kevin uses his Nano on the Skytrain.  
Godess ‘just’ uses Email and the Phone,  
I went to 7/11 to get a Cell phone.  
Sarah and Jake taught me how to text,  
Flower says, technology is helpful,  
And at times, it’s better to give it a rest.

Technology, through which entertainment, information and communication activities are conducted, plays a key role in enabling young people’s access to well-being enhancing experiences. The importance and use of technology cut across the socio-demographic circumstances in which young people lived. Even youth who had access to limited financial resources found ways to access technology. For instance, as the poem above illustrates, Smiley, who lives in a SRO building, obtained access to a cell phone during the course of her participation in the study, and Michael another youth living in a SRO building, had an iPad as well as a cell phone. Others, who did not have the financial means or resources to own such technologies, accessed the internet at community organizations and where public access to the internet was available (e.g., libraries).

The mind map of Kevin, illustrated in Figure 11, illustrates the role of technology in enabling him to construct and maintain a sense of self that is not constrained by an illness. The core experiences that he accesses in this regard are making and maintaining connections with others. Whereas in the physical world, Kevin spends much of his time in settings specialized for persons

---

42 Abbreviation for single room occupancy
with mental illness, in the virtual world he spends time in activities and spaces that are commonly frequented by the broader population of his peers.

![Figure 11. Mind map from Kevin: Technology and well-being](image)

During the participant photography-elicited focus group meetings, in the context of which young people were asked to take pictures of activities, people, places, and objects meaningful for their well-being, several brought pictures that were technological in nature. They took pictures of their cell phones, their iPods, as well as spoke in the group of other portable technological objects considered important for their well-being, such as laptop computers and cameras. These objects enable them to: connect with peers using social media and texting; maintain relationships with families at a distance through playing on-line games; stay in contact with family and/or friends through email and mobile technology; access information and resources through the internet; find their way around town through Google maps; and be entertained through their iPods and computers among many other valued activities and experiences.
The importance of technology in young people’s lives gradually became apparent to me as the study progressed. At the beginning of the fieldwork, when I first met Nelson, I had just purchased my first cell phone (I had previously never owned one) from a 7/11 store, a rudimentary one at that, specifically acquired for this project. In contrast, I noticed that Nelson had an iPhone sitting on his living room table. He in turn, introduced me to it in detail, describing how “cool” it is; indeed, I also thought, it was ‘neat’ that he had one. In the process of describing the iPhone, he also explained to me how he loves to pass his time in the Apple store downtown.

I had yet to discover the powers (and potential downfalls) of texting, until I started receiving texts from young people in the study and had to figure out how to respond! Thankfully, Sarah and Jake, bemused by my predicament, taught me how to text more efficiently on my low cost cell phone, leading to several communications with them and other young people through texting over the duration of the study. A few interviews later, Michael introduced me to the iPad. I recall saying to him, “It’s too bad one can’t make phone calls on it,” to which he responded, “Sure you can,” and then demonstrated the use of free applications through which this is possible. Alas, I started to realize that I was at high risk of becoming a walking, talking, technological dinosaur, if I did not do something about it. An evolution ensued; I transitioned from never personally owning a cell phone, to owning a pay-as-you-go rudimentary one, to now being an: Iphone, Ipad II, MacBook pro, all integrated by cloud technology, user. Thus, not only was technology a vehicle through which young people were observed to cultivate their skills, it is also through this medium that they directly contributed to the cultivation of mine.

Technology enabled young people and me to build and maintain connections longitudinally over the course of one year. Through email communications, Kevin sent me excerpts of his writing to help me better understand his experiences. I got to know young people in a different light, in other words, saw different aspects of their identities, when I watched their YouTube videos, read their profile posts, received their emails, or viewed their WebPages.

**Social and structural environment.** The data illustrate that the social and structural environment support, and in some cases hinder, young people’s efforts in striving towards their well-being. Three key themes in this regard were identified. First, the social environment’s (e.g., family, service providers, and peers) provision of instrumental, informational, and emotional
support, was commonly identified by young people as being helpful for their well-being. Second, the data also reveal that young people’s successful navigation towards, and engagement in, activities considered highly valuable for their well-being is contingent upon the social, structural, and economic contexts that they are situated in. Third, the socio-structural environment, in the form of services and formal supports, have the capacity to influence young people’s processes of resilience in paradoxically negative ways through engulfing, ghettoising, regulating, and being out of tune/disconnected practices. Each of these three themes are explained and illustrated in the following sub-sections.

**Instrumental, informational, and emotional support.** The presence of family support (and/or peer support) and supportive interactions with service providers was a prominent aspect of the environment that young people identified as being important for their well-being. In particular, young people identify three features of support derived from the social environment that they identify as being well-being enhancing: instrumental/accompaniment, informational, and emotional. These features will be explicated in further detail in the subsequent passages.

When I ask Kevin to describe to me one of the most meaningful ways in which others have helped him, he responds by describing how his father used to instrumentally support him in engaging in a physically active lifestyle through accompaniment:

Well, there’s my dad who took me out jogging when I was younger. He actually forced me to go out with him every morning to go jogging with him, and there was just a lot of hands-on work that he did with me then, to get me up to the point where I could jog continuously for 45 minutes.

Across several interviews, Kevin expresses his current desires for increasing physical activity in his life. At the same time he recounts the struggles he faces in this regard, and particularly in relation to lack of social support. He explains, that currently his mother and stepfather “try” to help him, by taking him for walks, but “it’s so limited in its application” because “it’ll just be one walk for one month, maybe.” This is the example he provides in relation to what he has found least supportive in terms of the ways people have helped him in the recent past. There is a theme in Kevin’s narrative that speaks to the adage of ‘actions speak louder than words.’ He notes, that although his parents suggest “ways for me to get active…they're kind of lax in what they'll do.” This theme arises again in his description of how he experiences the efforts of service
providers in helping him to engage in a healthy lifestyle, which in his account is restricted to goal setting and monitoring, with limited steps in between:

Well, they meet with you like once a month at first to follow up and see how you're doing with the goals. But, like, I hadn't made any progress on them because I wasn't motivated to. And so when I came there and told them that, they were just like, ‘Oh. Well, do you still want to keep these as goals?’ And I was just like, ‘No, not really.’ And so they basically dropped them, and now I don't have anything to do with the metabolic clinic.”

When I ask Kevin how service providers could be more helpful to him, he responds by recommending more active efforts in helping him get involved in a fitness centre or running group. Over the course of the study, Kevin is referred to a physical activity group specialized for people with mental illness, but does not go. In a follow up interview he states the reasons for him not attending the group are because he is scared of embarrassing himself, and that it would help “to have someone there with me through every step like a personal trainer.” Ultimately Kevin is seeking from his environment to go “above and beyond to reach out to people and bring them into a healthy lifestyle” as he emphasises that “it's a big thing to ask for someone to be physically fit when they're used to a lifestyle of sedentary living.” For other young people in this study, the active presence and accompaniment of social supports play a key role in their ability to engage in regular physical activity. For example, Maslow goes swimming with his father, Lily goes regularly to the recreation centre with her mother, and Smiley practices martial arts with her friend.

Interactions with service providers, families, and peers, when perceived as embodying emotional and humanistic support, also play an important role in facilitating young people’s well-being. By humanistic I am referring to interpersonal principles such as: being kind/respectful, being accepting, having a non-judgemental attitude, and being encouraging and hopeful. Participants who perceive their providers as believing in their capacity for personal growth and change, and who experienced encouraging interactions with them, often identified these as particularly significant for their wellbeing. For example, Godess describes how her psychiatrist has had the “most effect” on her life, in that she is committed to helping her, and “believes” in her. Ross describes the profound impact that his case manager has had on his life and in doing so outlines several humanistic features of his case manager’s interpersonal style:
This guy is so kind… He's very comfortable, very secure. And you're like, wow, this guy really makes me feel comfortable and at home. He's always encouraging, and he always has a smile on his face. When you walk through that door, he shakes your hand every single time. And every time you leave, he shakes your hand. He shows that he has respect for you, of the challenges that you're going through…He's always positive about things…Amazing role models like that, who can show you and help you and believe in you. They make all the difference because they show you what is possible.

Comparing and contrasting the accounts of young people recruited from the two sites.

In this section, I will illustrate how young people’s successful navigation towards, and engagement in, activities considered highly valuable for their well-being is contingent upon the social, structural, and economic contexts in which they are situated. This illustration is approached through a presentation of a series of contrasting accounts particularly in relation to young people recruited from the EPIP and the YMHP. Thus, the section begins with a recall of Flower’s narrative (recruited from the EPIP); this time attending to how the environment supports her art making activities. This will be followed by the situated experiences of young people (recruited from the YMHP) who are living in different social (e.g., social supports), structural (e.g., housing), and economic circumstances (e.g., financial resources).

Flower identifies herself as an artist and has been developing her art skills since high school. Flower considers art teachers from high school, along with those from college, as role models in her life. When she was in high school, a teacher identified the gift in Flower’s artistic abilities and encouraged her to hone her skills. Flower eventually attended art school and completed a Bachelor’s degree in Fine Arts. She is currently exploring the idea of pursuing the field of art education and emphasises that it is important for her to find a career that fits with her abilities, matches her interests and passion, and is practical enough to support her financial sustainability. Currently, Flower is self-employed as an artist.

Flower’s account provides an exemplary illustration of how the social, structural, and economic environment can support young people’s ability to navigate towards, and engage in highly valued activities. Her teachers, family, and friends recognize her potential as an artist and provide encouragement to pursue her artistry. She also derives financial support, structural stability in terms of housing, and access to education from her environment, all of which support
her process of building a career as an artist. She is able to afford the materials necessary to pursue her artistic endeavours as well as the education to cultivate her skills in this area. Her academic education and socio-economic situation equip her with the technological, social and literacy skills and resources that she draws upon to seek opportunities to engage in commissioned work. As such, she is also able to balance her time working as an artist with other activities she considers important for her well-being such as going to yoga, eating healthy, singing in a choir, attending festivals, working out at the gym, and socializing with friends and family. Flower’s stable socio-economic situation and supports enable her to orchestrate a daily schedule of valued activities, with art making at the center stage of her life. In other words, Flower’s environment demonstrates the capacity to provide access to a set of resources that enable her to engage in a diverse range of highly valued activities.

Contrast Flower’s account to Smiley’s, whose efforts towards engaging in activities valuable for her well-being are hindered by the social and structural elements of her environment. Smiley lives in a SRO building in the downtown area of a Canadian urban setting. She struggles with substance abuse, particularly alcohol, and is estranged from her family, which she does not like to speak about. Smiley is highly stressed by the rules and regulations of the building she has been “placed” in, as well as the ghettoized nature of its setting; she emphasises that she is not a “crackhead” and she doesn’t belong there. She does not like to stay in her room and building for long periods of time. Thus, Smiley moves around a lot, as a coping mechanism; in other words, as a way to get away, from her environment.

Smiley speaks passionately about two activities, playing the guitar and practicing martial arts, however she explains that she is unable to fully engage in these two activities due to several barriers. She would like to take her guitar with her when she moves around but hasn’t been able to afford a guitar case. Moreover, her ability to play the guitar in her room is dependent on her mood and alcohol use. Her mood and alcohol use in turn are influenced by the environment in which she lives. Thus, it is more than just a lack of a guitar case that limits Smiley’s ability to engage in activities that are of value to her. She explains, living in a ghettoized environment, in which her social freedoms are constrained through building rules and regulations, contributes to symptoms of depression and anxiety, and she copes with her situation by resorting to alcohol. Smiley’s ideal day, is being in her “own place” and being able to spend hours playing the guitar and practicing her martial arts.
Contrast Smiley’s account to Darren’s. Darren has been living in a youth shelter for the past year. He appears to me as a shy, low key young man of few words; however, when we broach the topic of music and guitar playing, he lights up with passion and animation. Darren is an avid musician. He spends 6 hours a day practicing his guitar in his room at the shelter. For Darren, playing the guitar is a source of refuge from his current life circumstances, and he explains, it keeps him away from getting into trouble. Playing the guitar provides Darren with an orientation towards the future that is instilled with hope for a better life. Darren practices guitar six hours a day and receives guitar lessons paid for by a member of his family; he wishes to become a professional musician.

Finally, Flower, Smiley, and Darren’s accounts can be usefully contrasted to Carl. His narrative illustrates that it is not simply the availability of resources that is important, but the capacity of the environment in providing access to the right fit of resources. Carl is a young man who lives in a SRO building. He has been living on the streets or in precarious housing since the age of 17. Presenting with occasional inappropriate and disinhibited behaviour, and limitations with concentration, Carl appeared to be one of the most affected by symptoms of psychosis when compared to other young people in this study. Carl identifies hockey and working as meaningful activities for him, neither of which he currently engages in. He states that he does not have access to the appropriate hockey gear in order to play, but continues to be an avid hockey game viewer.

During the course of the study, Carl is referred to a carpentry program. He is required to be at the program daily from 9-3pm. The program is located 1 hour away by public transportation. Social workers facilitate his access to the program by picking him up in the morning, and driving him to and fro on a daily basis. This lasts not more than 1 week after which he quits (or possibly was kicked out) of the program. He tells me that he hated the math part, in which he was expected to sit in a classroom for an extended period of time and do homework. While it is clearly a well-intentioned and even heroic attempt on the part of social workers to facilitate access to this activity and resource for Carl, the way the program is structured evidently does not match Carl’s current functioning abilities. Given that Carl has difficulty staying focused during our conversations for more than six minutes at a time, it is hard to imagine his ability to be focused in a program for six hours a day. In summary, these contrasting accounts
endeavour to illustrate how structural as well as social elements of the environment appear to enable or disable young people’s processes of resilience.

Paradoxical influences of service provision on the process of normalizing-identity work. Treatments and services provided to young people are also experienced in paradoxical ways; in other words, not as would be expected. As such, in some ways, it appears that the service environment hinders young people’s efforts at sustaining, restoring, and enhancing a normal sense of self and identity. For example, although all participants in the study lived in the ‘community,’ they used terms such as prison, institution, hospital scene, and pre-school to metaphorically describe the settings in which they lived and/or received health related services. This provided a window through which to understand how the social and structural elements of service environments hindered young people’s well-being enhancing efforts. Through the metaphors and personal stories of young people, this section illustrates service related practices that counteract young people’s normalizing-identity work efforts, these include: engulfing, ghettoising, regulating, and disconnecting.

Engulfing

I find that because I’m so involved with the EPIP, and I’m so involved with stuff that deals with the illness, that it takes control of my social life and it’s all that I have on my mind, and it’s pretty bad. And it makes me not want to hang out with people so much. (Jake)

The above quote from Jake illustrates how some of the young people in this study experienced engulfment; in other words, felt overwhelmed by their levels of involvement with mental health services and treatment. At the time of our first interview, Jake had been attending the EPIP approximately three times per week for various meetings with his treatment team as well as group interventions. Jake’s account suggests that his social well-being is influenced by an illness identity that is at least partially mediated through his frequency of contact with services. In other words, the extent to which he is in contact with services brings into the foreground of his consciousness an identity of illness, which in turn socially and narratively blocks him from having a social life.

Similar patterns in relation to service engagement are observed in Nelson’s account. Nelson is a 24-year-old man living independently in a 1-bedroom apartment in a middle class Canadian neighbourhood. He has been receiving services from the EPIP for approximately two
years. Previous to moving into his apartment, Nelson was living in a group home for young people with mental illness, a period of his life that he describes as being imprisoned: “I lived in a group home for about two years before I moved here... It feels like I did some time, as they say in prison, I did some time, now I’m glad I’m out.” Yet, even though Nelson is finally “out,” his account conveys experiencing engulfment by the extent to which he is involved with mental health services. Nelson receives several services, most of which exist specifically for young people with mental illness. For the past two years, he has been attending a recreation group, two times per week, offered by a non-profit organization that provides leisure and education services to people with a “mental health condition.” He also receives services from a program offering leisure, education, and work supports to individuals with “mental illness” two times per week. Moreover, on a bi-weekly basis, he sees his case manager and/or psychiatrist at the EPIP.

Nelson is neither employed, nor going to school, and is financially supported through provincial assistance for persons with disabilities. Nonetheless, Nelson makes steady efforts towards gainful employment. He sees a job counsellor on a monthly basis at an organization specializing in providing vocational and educational services to individuals with a “mental health disability.” One day he expresses interest to his job counsellor about pursuing a career in acting. She eventually connects him to a theatre company dedicated to “people affected by mental illness.” Although Nelson is excited by the opportunity to engage in acting pursuits, he is disappointed by the fact that such pursuits are constrained within a mental illness context, one that he has been striving to distance himself from. To top this off, part of the theatre company’s name translates to the term crazy in Nelson’s native language; Nelson is well aware of the literal translation, and appears to be embarrassed by it. Thus, although Nelson strives to move on, and normalize his life, he faces a counteracting process of being engulfed by a multitude of well-intentioned mental health services and supports that reinforce and remind him of his illness identity. One could argue that the process manifests at some level a form of community institutionalisation, especially when hearing how Nelson is affected by it. Unintentionally and unexpectedly, I also become a part of the process that reinforces Nelson’s illness identity.

In the middle of our second interview Nelson states: “Your life is so much easier than mine.” Hoping I have heard incorrectly, I respond, “Sorry?” He elaborates, “Your life is so much interesting than mine.” “What's interesting about it” I ask, starting to feel like I was treading into deep waters. “I don't know, you don't have to be interviewed [chuckles]… when you get
interviewed a lot, you feel like you’re the one that thinks differently… I’ve been asked questions a lot, same thing [brief chuckle].”

In a telling moment between Nelson and I, I become acutely aware of how my researcher’s agenda, paraphernalia (e.g., tape recorder, paperwork), and interactions with him within the context of a study on young people recently diagnosed with psychosis (even though the ultimate intention of which is to understand resilience) inadvertently become obstacles in his process of restoring his normal sense of self and enhancing his identity. By the very nature of involving Nelson as a ‘subject’ of an inquiry situated within the field of psychosis, I become a pawn of an institutionalising process that Nelson is already subject to. My interactions with him unintentionally amplify his experiences of difference and abnormality. I/the study do nothing to contribute to Nelson’s self-esteem enhancement, and rather, to some extent, seem to be counteracting it.

Nelson and I are presented with an impasse, a paradoxical challenge of sorts. How can I, enculturated as a researcher, avoid reinforcing his difference while still moving forward with him as a ‘subject’ of an inquiry on young people recently diagnosed with psychosis? How can he continue to participate in this activity with me, without compromising his normalizing-identity work?

By identifying this tension, that is, by bringing the issue to my attention, we manage to collaborate in solving our quandary. During a ten minute break he successfully initiates and negotiates a normalizing interaction with me by asking what my favourite subject was in high school. I agree to partake in this invitation for self-disclosure resulting in an ordinary exchange of our high school experiences. Although young people may make verbal and non-verbal attempts to sustain, restore, and enhance a normal sense of self and identity through their everyday interactions with others (including service providers and researchers), appropriate responses to their efforts are also critical for success.

Nelson unveils for me, the engulfing, institutionalising process in which I have become an agent of, through my interactions with him and the context that unites us. In a similar way, housing support workers at his group home are also agents in this engulfing process of institutionalization through their interactions with him:

It’s sad; it sucks to be living there two years and you’re not really friends with the staff even though you talk with them all the time…I felt ‘that’s unfortunate for Nelson,
because he seems like a normal person’…Maybe some staff could hang out with people that earn trust so they’re allowed to do things like outings. But they would have to be professional…there can’t be any crossovers like drugs or sex and crime with each other or whatever, it would be more like outings, you know, just have a coffee outside both of you, talk, you know…I hoped that that could be arranged, changed, be improved over there. I would have loved that.

Thus, while mental health services and service providers have the capacity to provide Nelson and other young people with meaningful opportunities for health, social, leisure, and vocational activities, they also have the capacity to reinforce young people’s experiences of difference and sense of being undervalued. This presents as an opposing force to their efforts in striving towards a normal sense of self and enhanced identity. In response, young people either seek contexts that enable them to distance from being associated with having a mental illness thereby restoring feelings of self-worth, and/or negotiate for more normalizing interactions with service providers, and with researchers as well. During the course of the study, Nelson moved back to his hometown, perhaps, in part to escape the institutional forces acting upon his normalizing process, and started attending a mainstream acting school.

It is important to note that other young people in this study who are exposed to similar settings as Nelson respond in strikingly different ways. Take Kevin, as a case in point, who is involved in as many mental health services, activities, and settings as Nelson (of which many are the same). Kevin is a young man attending the EPIP for approximately eight months. Over the duration of the study, I observe Kevin getting increasingly involved with mental health services as opposed to the other way around. This occurs through facilitation/referral from his occupational therapist and case manager at the EPIP. In fact, the only activity that Kevin engages in that is outside of a setting specialized for individuals with mental illness, is volunteering at a library, an opportunity he accessed himself based on preliminary information he ascertained from a peer. Evidently, Kevin is not affected by stigma in the way that other young people in this study are. He is generally appreciative of the referrals provided to him by the EPIP. I meet with Kevin 4 times either individually or in the group context over the course of a year. During this time, he moves into a group home in the city for young people with mental illness. He also gets involved with a theatre company dedicated for individuals with mental illness. He appreciates the opportunity to be able to write and act in the context of this company. He is not negatively
affected by the fact that the content of the company’s productions is focused on mental illness, and rather engages in it just like he would any other topic of general and/or personal interest to him, such as science fiction.

The differential responses of Kevin and Nelson, to the same types of services they receive, seem in part to be related to their narrative practices of identity work. For example, Kevin adopts an embracing strategy towards being labelled with a mental illness, whereas Nelson adopts a distancing one. Thus, the more Nelson is exposed to mental health services and resources, the more this reinforces his experience of difference, negatively influencing his self-esteem and normal sense of self; whereas, Kevin appears to be unaffected. It is interesting to note, that Kevin highlights the practicality of his embracing response by stating, “Well, it’s a lot of resources that you don’t get access to otherwise.” Thus, while Nelson experiences being in a “group home for people with mental illness” as a prison, Kevin, perceives the same group home as access to a home and opportunities to socialize with others. Moreover, while Nelson perceives being involved with a theatre company for people with mental illness as obstacles to his “transition into society,” Kevin views it as an opportunity for acting, interacting, writing, and doing novel activities.

What makes Kevin adopt an embracing stance, while Nelson and others like Flower, adopt one that is distancing? In a fourth interview with Kevin, after developing a certain level of rapport, I discussed the narrative strategies observed in the data (e.g., distancing, reducing over-identification, embracing, abstaining) and Kevin’s response in the context of this discussion helps to illuminate some of the factors from his perspective which contribute to his embracing stance and stigma resilience:

I think there's been a huge shift on thinking around the mentally ill for the last 50 years or -- or even the last 200. I'm not sure why my circle of friends and family don't think anything strange about it. Maybe it's just because we're -- I was going to say strange, but that's so vague. We just have a lot of quirky characters in our family so -- although none of them have been diagnosed with a mental illness it's not that far away from what they are. So, I don't know, maybe that's why. And then my friends -- I don't know, they're -- they're just, very tolerant people….They visited me in the hospital; we just got along like we normally did. We didn't really talk about it. We made a few jokes about it, but, like,
we didn't really discuss it very much because it was so hard to discuss because I couldn't really remember specifics so, yeah.

Kevin’s knowledge about changing perspectives on the topic of mental illness, his family background, and the tolerance of his friends are factors that contribute to his stigma resilience and embracing approach. Maslow, who also adopts an embracing approach, similarly describes family and close friends as being tolerant, open and accepting to his hospitalization.

_Ghettoising_

Young people’s accounts, particularly those living in SRO buildings, illustrate how the ghettoized characteristics of their environment counteracted their efforts to strive towards their well-being. By ghetto, I mean a setting that is occupied by a minority or marginalized group. Examples from the accounts of Philip, Smiley, and Michael will be used to illustrate this idea.

Philip is a young man living in a SRO building in downtown and struggling with substance abuse. Philip experienced symptoms of psychosis for approximately three years before starting to take medication regularly. Philip does not like the building or the neighbourhood in which he lives. His description of his residence and its surrounding neighbourhood echoes an illustration of a ghetto:

Every time you walk down the street you see someone on a crack pipe, a crystal meth pipe, a pot pipe or drinking alcohol every block you walk here. And it’s nothing but trigger after trigger here, so it’s not the right environment for people trying to stay sober…all the people in here smoke dope so…it’s hard to, hard to find a place that you can socialize with sober people. I know narcotics and drugs and alcohol are going to be around everywhere I go, but it’s just the type of people that I’m concerned about right now. Just being around these kinds of people, it’s not the right place for me.

Other young people participating in this study who live in SRO buildings share similar perspectives. Recall Smiley’s account from previous sections that highlighted how her housing environment restricts her ability to engage in activities considered highly valuable for her well-being and contributes to her alcoholism. She, like Philip, explains how ghettoizing (in other words, congregating) young people in such environments counteracts their efforts in striving towards their well-being.
Young people also expressed feeling in danger within these environments. For example, Michael, another young man living in an SRO, provides a housing account that is replete with experiences of humiliation, harassment, and traumatization:

Some of the people that live in that building should not be in a building like that. Like it’s honestly a danger to them… There’s one that keeps harassing me, he actually torments me like, it’s a harsh hate crime what he does, it’s disgusting… people like that, they turn a building into something where you don’t even want to be there… I stay on the street more than I live there.

It is important to contrast here the ghettoised contexts in which young people like Michael and Philip live, to the group home settings that Ken and Godess live in, which are not experienced in the same negative ways. This may in part be attributed to the fact that the group homes contrast significantly to the SRO buildings inhabited by youth in the present study, in terms of aesthetics and location. The group homes are estate homes located in upper class Canadian neighbourhoods that have been converted into settings for persons with mental illness to live in, whereas the SRO buildings were once lower end hotels. A number of different marginalized groups now live in these SRO buildings, ranging from individuals living with chronic mental illness, addictions, and/or mainly economically deprived.

Regulating

Young people also experience the regulating practices of the group environments in which they live as inhibiting their efforts at striving towards well-being. By regulating, I am referring to efforts made by the environment to control behaviour through rules.

Darren is a 20-year-old young man who has been living in a downtown youth shelter for approximately one year. He receives psychiatric services at the youth shelter through the YMHP. Darren is on probation for criminal activity, which he avoids detailing; it seems due to shame and regret. He also appears embarrassed about his living situation, but alleviates this by emphasising that the youth shelter is a place for people who are trying to turn their lives around, contrasting this to what he originally thought it would be: a place with “a lot of crackheads.” Although he compares the physical aspects of the youth shelter to a “mini-motel,” he describes the rules imposed on him as infantilising, “I can't really go out and do anything with my friends
anymore because I have a curfew… I can understand it’s a shelter, but we’re not in preschool, you know what I mean?” He tells me he cannot access Facebook at the shelter, although it is the main way through which he keeps in touch with his friends. He also cannot receive calls directly at the shelter and does not have a cell phone. Moreover, he explains,

You can't watch TV until after 4:00pm on the weekdays. You have to be out of the house between 1:00 and 4:00. You can't go on the computers until after 4:00pm. You, uh -- what’s the other one? Oh yeah, you can't go on the computer, or go on TV after a night meeting. You can't swear, but that’s an understandable rule. You can't talk about drugs. What else can't you do? You can't watch any movies with drugs or anything. You can't watch movies over 18A. It’s a little ridiculous -- Oh yeah, you can't have any music with violence cause it might be a trigger.

In other parts of the interview, Darren emphasises he is trying “really hard” to turn his life around, behave more responsibly, and act like an adult. One can contrast these efforts with how the regulating efforts by his environment work against him, “Oh my God! 10:00? I'm 20 and I have a 10:00 curfew.” In this case, a structured environment organized with the overall intention of protection through rule regulation ultimately makes him feel like a child. Interestingly, I also found it to be a challenge to keep in touch with participants such as Darren and Bill, both of whom were staying at the youth shelter. On one occasion, I had to go through a receptionist, then a youth worker, and finally, got access to Darren.

The types of rules, which seem to be of most concern for young people, are those that inhibit their social well-being. For example, Smiley, a 24-year-old young woman, lives in a SRO building in downtown that she got access to through the YMHP. At first, it is challenging for me to engage Smiley in a conversation. She presents in tomboy attire, with a baseball cap. She sits with arms crossed in front of me, with limited facial expression, and keeps her gaze downwards. However, when I broach the topic of housing, she becomes quite animated, and vehemently expresses, “I don’t like it. It’s their rules. Like the guest rules, it’s really annoying; like I feel like I’m in an institution …It makes me feel like a retard …a group home.” This is the key concern for Smiley and the main topic through which she maintains engagement with me throughout the study.

Smiley is largely affected by rules because they inhibit her efforts to maintain her social well-being. She has two friends that she would like to spend time with in her room; however, the
building rules only allow one visitor at a time, and visiting hours prevent her friends from staying late or sleeping over. She states that she has no other choices but to hang out with her friends outside where they are more inclined to get into “mischief” and where their safety is at risk. Moreover, these rules compounded by living in a ghettoised setting, contribute negatively to her psychological and emotional well-being. Smiley emphasises: “it sucks, because I’m not a crackhead or a junkie... they shouldn’t put me in places like that, cause they know.” Smiley’s choice of words “put” and “place” are relevant to note. When someone is institutionalized, the phrase of ‘being placed’ is typically used. Smiley’s choice of words carries profound meaning in relation to the lack of choice and control she has in terms of the decision of where she lives. Smiley copes with her housing situation among other challenges through substance abuse, and alcoholism in particular. Her mental health service providers present her with a contingency plan that if she completes a substance abuse rehabilitation program, they will facilitate access to a better housing situation. A few hours into the rehabilitation program she quits because she cannot get access to her bedtime medication one hour before the prescribed time: “I wanted my Risperidal to go to sleep. But, they couldn’t give it to me ‘cause it was not bedtime, like, their bedtime. Their bedtime is, like, 9:00 -- 9:30. It was pretty close. It was, like, 8:00 or 8:30.”

Young people are not entirely against the idea of rules. Rather, they suggest a reasoned and tailored approach to the imposition of rules as opposed to a one-size fits all strategy. For example, participants in this study who live in group home settings express appreciation for having a stable home. However, an untailed or unreasoned approach to rule setting and implementation also inhibits their ability to feel at home, as Ken explains:

It's not so much that I don't like to conform to these rules, it's just, this is where I live, right? I'm trying to get better so I'd like to have at least a sense of being comfortable where I live and a sense of having a home... I've even told the staff here one thing that would be better is to have, like, different levels. So, if you do something wrong then you get that taken away. And then you have to realize, okay, this is what I need to work on. But if you're being punished for doing nothing it's, like, what did I do wrong?
Several participants in the study described service providers’ interactions as being out of tune or disconnected with their instrumental, informational, or emotional support needs. For example, Godess makes reference to health care providers occasionally “throwing question after question, without an inkling of caring” which makes her feel “worse” as opposed to better. She appreciates the importance of “being professional” but feels that there is superficiality in service providers’ approaches that lacks the communication of empathy and caring:

If they were a little more in tune with, like, how you’re feeling--and they didn’t just say, ‘Oh, blah blah’ they’re all bubbly and positive all the time...It would be nice if someone came up to you and say, you know, ‘How are you feeling today? Are you all right?’ …You know, instead of asking a million questions about ‘what did you do today and lala-lala’ like, let’s talk about things----that mean something, you know, especially when I’m not feeling well…You have to kind of use your knowledge about what’s appropriate for that person.

Like Godess, other young people’s accounts of interactions with service providers are imbued with the theme of being out of tune, or disconnected with their needs. Such interactions are sources of frustration, as Ken’s account illustrates. Ken describes being subjected to a vocational counselling assessment that he perceives little rationale for, as he has already chosen a career path for himself. He states that his key need is to receive instrumental supports regarding the pursuit of his chosen career path (e.g., obtaining loans and bursaries). Notwithstanding his resistance, he recounts his service provider’s insistence on moving forward with a vocational assessment agenda:

I forget what they’re called where you do all those stupid questions and they come out with a form. And I already told them, no, I don't want to do this. I already know what I want to do…And it's just kind of running through a wheel … Like, they treat everyone as the same client. And they give them the same psychology test and the same thing. And they should just talk, like, honestly talk to them…it was just the tedious, sort of, monotonous questions that they're asking me. And it's, like, I can just tell you straightforward what I want.
The theme of being out of tune is also evident in young people’s accounts of receiving mental health related information. As Ken explains,

But I haven't had [name of mental health service provider] sit me down as, like, a friend-to-friend thing and tell me what [diagnoses] really is. He's just given me random sheets that say, oh, it's a disorder, blah, blah, blah…. Like, it would be better if [name] could actually go over it with you, make sure that the client is actually understanding what you're saying not just them saying ‘yeah, yeah, yeah.’ You know, try to get some feedback and interaction with them when you're talking to them about it.

Ken further explains to me that when young people are subjected to these types of encounters, which reflect information transfer rather than interactive conversation, they passively withdraw from the conversation while still being physically present (e.g., with the nod of a head and utterances of agreement).

Lily also speaks to a disconnected, lack of in-depth approach that she experiences from interactions with service providers, and suggests this as an area for improvement: “Not being as distant, instead of it’s always ‘are you taking medicine’ or ‘how much you’re taking’. It’s not really involved with personal issues. Yeah…That’s what I think could be changed.” Kevin brings up the notion of being timed or on the clock in the context of his interactions with service providers. He expresses that such interactions inhibit his ability of feeling comfortable enough to express personal aspects of his life. Near the end of our first interview, upon sharing his experiences of psychosis and related circumstances (e.g., stress at work, breaking up with girlfriend), Kevin makes the following point: “That hasn't been shared before. Like a lot of the stuff we're talking about, I've never talked about with anyone before.” I am somewhat perplexed by his comment, because normally such topics would arise in the context of taking a case history, therefore, almost in resistance to his statement, I respond, “I'm sure you've had some opportunity to talk, like with your health care team?” He insists,

Never to be so personal about it, though. It was always kind of detached, and I always felt like we were on the clock and not really supposed to talk about things like that...It just wasn't an environment where I felt comfortable with it. The people weren't really so emotional. They just felt detached in general. Like they were just doing their jobs and weren't really curious or interested. So, I didn't really feel like expressing myself.
Summary

In this third and final section of the findings chapter, young people’s narrative accounts illustrate the role that the technological, social, and structural aspects of the environment play in influencing their normalizing-identity work as they navigate towards, access, and engage in narrative practices, valued activities, and interactions. The environment interacts with young people’s efforts to produce differential degrees of success related to their normalizing-identity work. Instrumental, informational, and emotional supports appear to be key resilience enhancing features of support that are illuminated by young people’s accounts. While several aspects of services are expressed by young people as contributing positively to their well-being, the findings also indicate that services and supports inhibit young people’s efforts at striving towards wellbeing particularly through the practices of engulfing, ghettoizing, regulating, and being out of tune.
CHAPTER FOUR: DISCUSSION AND CONCLUSIONS

Synopsis

In this chapter, the findings are discussed in relation to the theoretical and empirical literature on resilience, well-being, and recovery in early psychosis (and mental illness more broadly). The findings are also considered in terms of their implications for future research and practice. The chapter begins with a presentation of the findings, outlined through five key points, which will then be discussed successively.

Integrated Summary of the Findings

The purpose of this inquiry was to advance understanding on how young people recently diagnosed with psychosis sustain, restore, and enhance their resilience. It adopted a qualitative approach, and as such responds to the call from researchers to focus attention on understanding the contextual and variable nature of the resilience process using qualitative methods (Ungar, 2003; 2004). The present study also addresses a critical gap in the mental health recovery literature. Most of the research exploring the meaning and process of recovery from the perspectives of persons with mental illness stems from American, New Zealand, and Australian contexts; moreover, it is largely confined to the perspectives of a relatively homogenous group in terms of age range, years of illness, and culture. For example, only until more recently, has research on the psychosocial process of recovery in first episode psychosis populations emerged (e.g., Windell & Norman, 2012; Windell, Norman, & Malla, 2012). The present study contributes to this emerging body of literature on recovery. The findings explicate a core process that young people engage in that appears to contribute positively to the quality of their recovery process; in other words, engaging in normalizing-identity work enables young people to achieve experiences of well-being which in turn supports their recovery. The findings provide a depth of understanding in relation to narrative practices, five core experiences derived from engagement

---

43 Parts of this chapter (specifically content that appears solely on this page) are derived from the following peer-reviewed, published paper: Lal, S. (2010). Prescribing recovery as the new mantra for mental health: Does one prescription serve all? Canadian Journal of Occupational Therapy, 77, 82-89. doi: 10.2182/cjot.2010.77.2.4
in valued activities, as well as environmental processes that promote and/or hinder young people’s agency following a diagnosis of psychosis in ways that have not been addressed in the recovery literature to date. In the same way, the findings bring attention to identity work and its relationship to sustaining, restoring, and enhancing resilience, and as such make an important theoretical contribution to the resilience literature.

At the outset of the study, I adopted Ungar’s (2011) conceptualization of resilience as being reflected in individuals’ efforts to navigate and negotiate towards resources considered meaningful for their well-being, and the environment’s capacity to support this process. In other words, well-being was considered to be the outcome that individuals strive towards. As such, an important starting point in the present inquiry was to understand the meanings of well-being from the perspectives of young people themselves. That is, what exactly were young people striving towards in relation to their well-being? A preliminary analysis on these meanings revealed the importance of identity and the subtext of normality in relation to young people’s well-being. Normalizing-identity work, which refers to how individuals sustain, restore, and enhance their normal sense of self and identities through narrative practices and engagement in highly valued activities, was identified as a core process of resilience. The findings can be further summarized through five key points:

1. Young people conceptualize well-being as broad, multidimensional, and influenced by engagement in action oriented states.

2. Psychosocial and structural adversities contribute to young people’s experiences of difference and abnormality; and thus, negatively influence their sense of self and identity.

3. Young people’s identity and sense of self, for example, reflected in their attention to: experiences of normalcy (thinking, looking, feeling, and being treated normal), self-esteem, and self-compassion, are embedded in their conceptualization of, and strivings towards well-being.

4. Identity work is a core process that young people navigate and negotiate to sustain, restore, and enhance their resilience. This identity work involves two key pathways, the stories they tell about their lives and the activities they engage in. Navigating and negotiating these pathways enables young people to: construct a normal sense of self and identity, and enhance their self-esteem and self-compassion. These processes ultimately contribute positively to their well-being.
5. The availability, accessibility, and meaningfulness of resources from the technological environment (in the form of information and communication aids), social environment (in the form of interactions that embody instrumental, informational, and emotional support), and structural environment (in the form of services and supports), have a key role in promoting and/or hindering young people’s resilience.

Discussion of the Findings in Relation to the Literature

Contributing to the conceptual dialogue on well-being

Key message #1: Well-being is conceptualized as broad, multidimensional, and influenced by engagement in action oriented states. As mentioned, an important starting point in the present inquiry was to understand the notion of well-being from the perspectives of young people themselves. This aspect of the present inquiry is novel in that individuals with mental illness have traditionally been overlooked as sources of knowledge on salutogenic processes within the well-being literature. Well-being, as an outcome of resilience, or adaptation more generally, has commonly been defined, at least in part, by the absence of psychopathology. This conceptual approach has historically rendered the labelling of individuals with mental illness into the non-resilient camp, assuming their limited access to well-being. In contrast, the present study demonstrates that youth recently diagnosed with psychosis do experience moments of, and enact their agency in striving towards achieving, well-being.

In the literature, well-being is broadly categorized and studied in terms of hedonia and eudaimonia. Hedonic well-being refers to emotional aspects, such as happiness, whereas eudaimonic well-being refers to strivings towards achieving one’s potential (Keyes et al., 2002; Ryan & Deci, 2001; Ryff 1989; Waterman, 1993). In the present study, while this distinction was not made at the outset of the analysis, both aspects of well-being were spontaneously illustrated in young people’s narrative accounts.

The present findings can also be considered in relation to Keyes’ (2005) two continua model, which conceptualizes mental health (which is equated to emotional, psychological, and social well-being) and mental illness as separate, but related phenomena. This model is strongly supported by large sample studies conducted in the general population of adults and adolescents.
(Keyes, 2005, 2006, 2009; Westerhof & Keyes, 2010). For example, in an American survey of 3,032 adults, individuals were assessed for symptoms and criteria in relation to psychiatric diagnostic categories as well as in relation to positive mental health (i.e., operationalized through measures of subjective well-being). Results demonstrated that 10% of the sample had no mental illness, yet still experienced poor levels of positive mental health; while 15% of individuals had a mental illness, yet managed to experience moderate levels of mental health (Keyes, 2005). Thus, even in the presence of mental illness, some fared better from a positive mental health/well-being perspective than those who did not have a mental illness. The tested model implies that mental illness and positive mental health are not necessarily derived from the same sources (Keyes, 2007). Keyes’ (2005) research challenges the approach of adopting the absence of psychopathology as core criteria for determining the presence of well-being, and the present study lends support in this regard.

Although Keyes (2007) has predominately used the two continua model for an agenda towards the promotion of mental health in the general population, I would argue that his model is noteworthy for clinical populations with mental illness as well. Similarly, Provencher and Keyes (2011) recently suggested that a complete approach to recovery, in relation to individuals with mental illness, should focus on restoration (alleviation of symptoms) and optimization (promotion of well-being). In this regard, it is important to understand well-being from the perspectives of different populations.

Keyes (2005), who generated a conceptualization of well-being based on the study of non-clinical samples, categorizes well-being into three key components, namely: emotional well-being (e.g., experiences of happiness), psychological well-being (meaning and self-realization), and social well-being (e.g., experiences of social worth and positive social relations). The findings from the present study indicate that such a conceptualization excludes dimensions identified by young people in the present study (e.g., physical, spiritual, and moral aspects of well-being). Concurrently, it is noteworthy that Windell et al.’s (2012) study on the meanings of recovery based on a sample of individuals treated for first episode psychosis, also did not reveal the domains of spirituality, physical health, and morality. The authors proposed that having a young sample (i.e., mean 25.9, SD=5.3 years) that represented earlier stages of the illness (i.e., 3-5 years following treatment for a first episode of psychosis) could be factors that contributed to the absence of these domains in participants’ accounts. However, this explanation is not
supported by the present study, which has a younger sample (mean 22, SD=1.9 years) that is earlier in the course of illness (3 months-3 years following treatment for a first episode of psychosis). Other factors that could explain the difference in findings between the present study and that of Windell et al.’s include methodology; the focus on well-being as an outcome, which may be tapping into a broader, more holistic concept than recovery as an outcome; differences between samples (e.g., ethnicity); and geographical location of the sample. For example, in terms of the latter, the present sample was recruited from an urban city located in the West Coast of Canada, wherein a “west coast lifestyle,” that includes engaging in outdoor physical activities and practicing yoga is popularized through the professional and elite classes (Veenstra, 2007) as well as the local media; indeed, the majority of participants in the present study spoke about the importance of engaging in physical activity and eating healthy in relation to their well-being and several spoke about spirituality and spiritual activities (e.g., going to sweats, practicing yoga, meditating) in relation to their well-being. However, participants also expressed concern with weight they gained during the first year of receiving treatment for a first episode psychosis, which may also be a contributing factor to the heightened attention on physical health in relation to well-being that was identified in the present study.

**Relating psychosocial and structural adversities to identity**

**Key message #2: Psychosocial and structural adversities contribute to young people’s experiences of difference and abnormality; and thus, negatively influence their sense of self and identity.** The present study indicates that young people’s sense of self and identity are negatively influenced by psychosocial adversities they have faced, or continue to face. These adversities include: de-stabilization from previous cognitive, perceptual, and affective states; service related reinforcements of their difference; self-awareness of deviation from their desirable levels of social functioning; stigma in relation to being labelled with psychosis; and, stigma related to socio-structural circumstances, such as living in substandard housing and being on welfare. These findings echo previous research that has demonstrated the impact of mental illness on individuals’ identity within the first episode psychosis qualitative research literature (Boydell et al., 2010; Macnaughton, 2008; Perry et al., 2007; Romano, McCay, Goering, Boydell, & Zipursky, 2010; Tarrier, Khan, Cater, & Picken, 2007; Windell & Norman, 2012),
and in the psychosis literature more broadly (Estroff, 1989; Roe & Davidson, 2005), albeit with less attention to the contribution of social-structural circumstances (e.g., housing and poverty) in this regard. Tarrier et al. (2007) reported on the negative subjective and psychosocial effects associated with a first episode of psychosis in relation to life disruption, stigma and social exclusion. The negative influence of stigma, in particular, on self-esteem has been observed in first episode psychosis populations (e.g., Windell & Norman, 2012) and in individuals with schizophrenia spectrum disorders more broadly (Yanos, Roe, Markus, & Lysaker, 2008). Low levels of self-esteem have been identified as key features in individuals with a first episode psychosis when compared to peers without mental illness (Pruessner, Iyer, Faridi, Joober, & Malla, 2011) and reported to be strongly associated with higher distress (as opposed to positive symptoms) even at the time of treatment initiation (Vracotas, Schmitz, Joober, & Malla, 2007). The present findings contribute knowledge to a wider range of factors (e.g., stigma, structural circumstances) that warrant further research attention as potential contributors to the low-levels of self-esteem (and sense of self and identity more broadly) observed in first episode psychosis populations.

Unpacking the notions of normality

Key message #3. Young people’s identity and sense of self, for example, reflected in their attention to: experiences of normalcy (thinking, looking, feeling, and being treated normal), self-esteem, and self-compassion, are embedded in their conceptualization of, and strivings towards well-being. It is noteworthy that within the qualitative literature pertaining to studies conducted with first episode psychosis populations, quotes from participants are replete with attention to identity in relation to normality. Similar to the present study, the term normal has been used in reference to: looking normal, feeling normal, or engaging in normalizing activities. These studies span a range of related topics, including: Macnaughton’s (2008) work on insight development; Windell and Norman’s study on the influences of recovery (2012); Perry et al.’s (2007) study on hope; Kilku, Munnukka and Lehtinen’s (2003) study on information giving; and Sin, Moone, and Wellman’s (2005) study on family perspectives of services. Examples of quotes from these studies help to illustrate: “Am I normal or is there any normal…?” (Kilku, Munnukka, & Lehtinen, 2003, p. 61); “He said that
you have to understand that people who are labeled [sic] with schizophrenia can still lead normal lives and they’re not shunned upon, or, you know…looked on as lower people in the world…so a lot of that…sounded promising to me” (Windell & Norman, 2012, p. 4); “I just want to be normal. I just want to be like everybody else” (Windell & Norman, 2012, p. 5); “You have to come back to some sort of normality so that you feel you belong here, no matter how different you are” (Perry, Taylor, & Shaw, 2007, p. 788); “I don’t think normal people should be sectioned with people like that” (Perry et al., 2007, p. 788). Such quotes and themes identified in previous work combined with the present study’s findings, lend credence to substantiate that young people recently diagnosed with first episode of psychosis are concerned with a sense of being normal and having a normal identity.

Previous qualitative studies in the early psychosis literature, however, do not delve into an analysis or discussion of normality, in terms of deconstructing the meanings, experiences, processes, and social constructions of it. In contrast, the present study contributes to the beginnings of such an endeavour by first deconstructing the taken for granted, differentiated meanings of normal within participant accounts. The findings indicate that young people’s meanings of the term normal are influenced by personal, psychological, historical, and social circumstances. Personal factors such as exposure to specific types of familial attitudes, personal history, and socio-economic circumstances, all interplay in the process of developing a subjective position on what it means to be normal. They draw upon ideas, beliefs, and attitudes from their environment (e.g., dictionary definitions of normal, media representations) to construct their understanding of the phenomenon of normal. In doing so, they concurrently navigate and negotiate biomedical, cultural, and social discourse pertaining to psychosis and mental illness in their efforts to construct a normal and positive sense of self. Thus normal, is a social construct; our understanding of the phenomenon is dependent upon social, personal, and historical factors (Walsh, 2012). The findings suggest that to understand what is meant by normal, three perspectives are equally important: those emanating from the broader environment, those subjectively determined, and the interplay between both.

Normal is defined by the dictionary as: “not deviating from a norm, rule, or principle;” “conforming to a type, standard, or regular pattern;” “occurring naturally;” “relating to, or characterized by average intelligence or development;” and, “free from mental disorder.” Antonyms of normal include: abnormal, odd, strange, and unusual; and near antonyms include:
queer, atypical, irregular, untypical, bizarre, wacky, freak, oddball, and weird (Normal, 2011).

What is this normal that young people strive towards? It is not as straightforward as one might assume. While young people’s meanings of normal converge with the aforementioned dictionary definitions, they also extend them. The term normal conveys profound meanings for young people’s sense of self and their engagement in identity work. Young people in this study refer to normal as: a typical event/occurrence; not pathological; being free from psychiatric symptoms; and related to activities, settings, interactions free from having anything to do with mental illness. Moreover, normalcy is: a sub-text of identity; a strongly valued personal and interpersonal lived experience; and a point of reference in terms of past behaviours, states, and functioning. The subjective meaning of normalcy from young people’s perspectives is attributed in part in relation to having experienced abnormal mental states, in part in relation to the perception of being in undesired modes of performance and functioning, and in part in relation to social identity.

Perhaps the most powerful implication of the dictionary definition on normal is its reference to being free from mental disorder which some of the young people in this study have adopted and taken a step further. The definition seems to imply that having other types of disorders, such as physical ones, is considered normal, whereas having a mental disorder is not. Understood from this perspective, one could attribute a stigmatizing undertone in the dictionary definition of normal that infuses understanding of mental illness within society and permeates young people’s understandings of themselves. As Mullins (2010), an American athlete and amputee who speaks publically on the topic of adversity, highlighted: words and their associated meanings circulating in society, can have powerful influences on an individual’s identity. Specifically, she stated:

It’s not just about the words, it’s what we believe about people when we name them with these words, it’s about the values behind the words, and how we construct those values. Our language affects our thinking, and how we view the world, and how we view other people.

In his seminal text, Stigma: Notes on the Management of Spoiled Identity, Goffman (1963) suggested that “the stigmatized individual tends to hold the same beliefs about identity that we do…His deepest feelings about what he is may be his sense of being a ‘normal person,’ a human being like anyone else” (p. 7). With this statement, Goffman set the stage for outlining the
theoretical relationships between stigma in relation to normality, and how individuals affected by stigma manage their interactions with others in their efforts to experience acceptance, which he characterized as “the central feature of the stigmatized individual” (p. 8). He further argued that stigma can be understood through “a language of relationships” (p. 3), thereby highlighting the importance of viewing stigmas (and I would add here the notions of normality) in relation to the dynamic perspectives held, as opposed to static attributes possessed.

It is important to note that while participants’ accounts highlight the importance of the subtext of normality, others have challenged the utility of such a focus. For example, Mullins (2010) states:

The greatest adversity that we've created for ourselves is this idea of normalcy. Now, who's normal? There's no normal. There's common, there's typical. If we can change this paradigm from one of achieving normalcy to one of possibility -- or potency…we can release the power of so many more children, and invite them to engage their rare and valuable abilities with the community.

From a post-modern perspective, normality is a complex phenomenon that is embedded in a web of social, cultural, biomedical, and interpersonal discourses that do not necessarily converge, and young people are continuously navigating and negotiating such discourses through their micro, meso, and macro level interactions with the health care system, community, and society. Coming to an answer about what normalcy is or should be, and how it can be achieved, is therefore beyond the scope of, and is not really the intention of this discussion; however, the findings do provoke a need for further consideration from research and practice in this area, and from the perspectives of various stakeholders.

**Viewing identity work as a core process of resilience**

**Key message #4: Identity work is a core process that young people navigate and negotiate to sustain, restore, and enhance their resilience.** A recent review of qualitative studies on the subjective experience of first episode psychosis highlighted identity work as a key theme in participants’ narratives (Boydell et al., 2010). For example, in their study, Romano, McCay, Goering, Boydell, and Zipursky (2010) illustrated that identity work occurs through five broad stages which involve: questioning past lives; encountering an interruption; engaging in
services and supports; re-engaging in life; and envisioning the future. Moreover, young people in Perry, Taylor, and Shaw’s (2007) study on hope were actively engaged in identity work, and the process of adjusting their perspectives following a first episode of psychosis. Similarly, studies have also demonstrated that developing a positive, effective, and agentic sense of self is both part of the recovery process and influences it (e.g., Davidson, 2003; Estroff, 1989). The present study contributes to, and expands upon these aforementioned studies, by explicating how young people construct and enact a personal identity that reinforces experiences of normalcy and enhances their well-being. It shows that young people navigate and negotiate discourses, activities, and settings to resolve the tension of acquiring stigmatized identities with maintaining, restoring, and enhancing aspects of their selves that they would like to project.

Normalizing-identity work through narrative practices. Young people in the present study engaged in identity work through the form of narrative practice; that is, the stories they tell about their lives and the resources they use to tell those stories (e.g., discourse). The importance of narratives, that is, the stories that people tell about themselves in relation to their illness, as a key aspect of recovery, has been well articulated in the literature (e.g., Kleinman, 1988; Lysaker & Buck, 2006; Roe & Davidson, 2005). Moreover, research suggests that the way in which individuals tell stories about their lives contributes to the enhancement of well-being (Bauer & McAdams, 2004). The present study further elaborates by illustrating how young people narratively sustain, restore, and enhance their identities in response to being diagnosed with, and affected by psychosis in a way that serves to normalise their experiences and ultimately contributes positively to their well-being. In a study that sought to understand how homeless people construct and negotiate their personal identities that provide them with self-worth and dignity, Snow and Anderson (1987) similarly concluded that identity talk is a key way through which individuals attend to their need for self-worth.

Youth in the present study selectively draw upon discourse from their immediate and broader environments for the purpose of enacting narrative practices, which serve to preserve and enhance their salutogenic, normal sense of self, and ultimately their well-being. Larsen’s work (2004) also illustrates how individuals creatively draw from a range of cultural resources from their environment (e.g., systems of explanation for experiences, such as a biomedical one), to construct an adaptive explanatory model of their experiences. Findings from the present study
elaborate further by indicating that young people employ three types of narrative practices that discursively enable them to articulate their positions vis-à-vis: the biomedical system of explanation for their psychosis experiences, the label of psychosis, and the meaning of illness within the biography of their lives. Some of the discursive strategies employed in this regard, serve to distance young people from the label of psychosis and the stigma associated with it. This helps to reduce their experiences of difference and preserves their sense of normality. While this stance could be interpreted as a denial of illness, and further construed in a pathological manner, others have argued that narrative accounts manifesting denial of illness may in fact represent attempts at preserving one’s healthy sense of self (Estroff, 1989). For example, Estroff (1989) suggested that individuals make “normalizing statements” (p. 191) to minimize their experiences of difference and reclaim a “not-disordered” (p. 191) self. Similarly in Macnaughton’s (2008) narrative research on insight development conducted with individuals recently diagnosed with psychosis, participants employed normalizing explanations of their illness as an attempt to protect and regain control over their sense of self. Snow and Anderson (1987), in their study with homeless individuals, also identified different forms of talk through which participants constructed a personally desirable identity despite their social circumstances. Three key forms of talk documented in Snow and Anderson’s study were: distancing, embracement, and fictive storytelling. The first two of these forms are identical to those uncovered in the present study suggesting the potential transferability of these strategies to other populations affected by stigma.

Normalizing-identity work through the form of engagement in highly valued activities. A second form through which young people engaged in identity work was through valued activities. These findings contribute to an important gap that has been highlighted in the mental health literature. For example, conclusions from a recent review of qualitative studies in the field of early psychosis highlighted a gap in knowledge on activity engagement and recovery in early psychosis (Boydell et al., 2011). Within the mental health literature, others have also called attention to the need for research on the experience of activity engagement within the context of mental illness and recovery (Aubin, Hachey, & Mercier, 1999; Leufstadtius et al., 2008).

In the present study, young people’s accounts indicate that engagement in highly valued activities is associated with experiences of, and strivings towards well-being. Highly valued activity engagement is a key mechanism through which identity work occurs and which leads to
well-being. What is it about highly valued activities that make them meaningful to young people in terms of their well-being? The findings indicate that highly valued activities have a therapeutic, social, and normalizing dimension, and facilitate access to well-being through five core experiences: creating-expressing meaning, calming or energizing the self, connecting with others, contributing to others, and cultivating skills, virtues, and strengths.

The posited relationship between meaningful activity engagement and well-being is a central tenet in occupational therapy and occupational science; and, it has roots in Aristotelian thinking wherein it is considered that a human life of richness is partially predicated upon having the “freedom to undertake important activities that a person has reason to choose” (p. 4) (Sen, 2000). While it is surprising to note that meaningful activity engagement has been given limited attention in the resilience literature, the contributing role of activity engagement to well-being has been empirically identified across other disparate bodies of literature. These include studies within the topical areas of occupational science (Anaby, 2010; Wilcock et al., 1998); occupational therapy (Doble & Santha, 2008; Hayward & Taylor, 2011); well-being (Waterman, 1993); activity engagement, recovery, and mental illness (Borg & Davidson, 2008; Deegan, 2005; Leufstadius, Erlandsson, Bjorkman, & Eklund, 2008; Sutton, Hocking, & Smythe, 2012); and recovery and early psychosis (Windell & Norman, 2012).

In a recent qualitative Canadian study conducted with young people following a first episode of psychosis, conducted by Windell and Norman (2012), participants experienced valued activities as being critical to their process of recovery. Such activities provided opportunities to develop strengths and skills, help others, and consequently enhance self-esteem, self-worth, meaning, and purpose in life. Participants also valued engagement in developmentally appropriate activities which take place in mainstream settings. Within the mental health recovery literature more broadly, the therapeutic dimension of activity engagement was found in Deegan’s (2005) qualitative study. She initially set out to explore the experiences and perspectives of taking medicine among a group of individuals with mental illness. Participants instead focused on how valued activities in their lives (e.g., singing, solving math problems) formed an important

---

44 Occupational science is a field of study that draws from biological, psychological, social, cultural, geographic, and symbolic knowledge to develop understanding about the experience and engagement in personally and culturally meaningful activities (Clark et al, 1991). The application of an occupational science perspective to the systematic study of the resilience phenomenon has not (to the author’s knowledge) been undertaken to date.
part of their personal medicine, by serving to address their anxiety, depression, distressing voices, thoughts, and concentration. Recently, Eakman and Eklund (2012) demonstrated that meaningful and valued activities were significant in explaining life satisfaction and life meaning in a sample of 224 undergraduate and graduate students, providing additional support for the importance of the relationship between activity engagement and well-being.

Expanding further into the breadth of the literature base, the relationship between engagement in subjectively valued activities and well-being has been identified in Waterman’s (1990, 1993) well cited work. His landmark studies (Waterman, 1993) of 458 undergraduate and graduate students examined the conceptual convergences and distinctions between eudaimonic and hedonic well-being. Results substantiated that engagement in activities of importance is a key pathway through which eudaimonic well-being is obtained. It is important to note that in contrast to the present study’s approach, Waterman did not make a distinction between importance and those activities prioritized by participants as being of high value. I would hypothesize instead, based on the present study that activities which are highly valued by young people and supported by the environment, can contribute in significant ways to their well-being when compared to daily activities, or activities of importance, more generally. The reason put forth here for this hypothesis is that highly valued activities may provide access to multiple experiences that are core to individuals’ well-being.

The relationship observed between highly valued activities and well-being also converges with evidence from the occupational science literature. For example, Anaby (2010) used structural equation modeling to test a model examining the role of activities in terms of their effect on well-being in an adult general population sample, and found that the characteristics of activities, namely their valued meaning to the individual and his/her identity, was more important in explaining well-being than other factors such as the extent to which activities were organized in daily life. The tested model also revealed that self-efficacy in activity engagement and sense of control over the activities contributed to well-being. In light of the present study’s findings, and drawing from Anaby’s results, one could hypothesize that the more individuals engage in activities considered highly valuable for their well-being, and for which they perceive self-efficacy and control, the more enhanced their well-being will become.
**Self-esteem and self-compassion enhancement: Mediating processes of resilience?** The present findings suggest that self-esteem and self-compassion were both a concern for participants and that engagement in identity work (e.g., through narrative practices and highly valued activities) facilitated the enhancement of these psychosocial resources. Windell and Norman (2012) identified a similar relationship between valued activities and enhancement of self-esteem and self-worth in the context of a qualitative study on recovery in first episode psychosis. Self-esteem has been positively correlated with global outcomes in functioning at six months in a first episode psychosis population (Vracotas, Iyer, Joober, & Malla, 2012) and similar results have been found in the psychosis literature more broadly (e.g., Roe, 2003). In the resilience literature, self-esteem has been replicated as a predictive factor associated with positive adaptation in the face of adversity (Masten, Best, & Garmezy, 1990). Moreover, Rutter (1987) has suggested that the establishment and maintenance of self-esteem might point to protective mechanisms that help individuals negotiate risk, and as such warrants further investigation.

The findings from the present study also shed light on the potential role of self-compassion enhancement for well-being in early psychosis, an area that has been given little attention in the first episode psychosis literature in terms of empirical, theoretical, or conceptual focus. Young people’s mantra statements such as “loving yourself,” “accepting yourself,” “taking care of yourself,” and “being kind to yourself,” illustrate the importance for, and how they strive towards, self-compassion enhancement. Recall that self-compassion is defined in the literature as feelings of acceptance and kindness towards the self (Neff, 2009, 2010). In a general adolescent population sample, self-compassion correlated with well-being and also partially mediated associations between family factors and well-being (Neff, 2010). This converges with findings from the present study that illustrate how young people’s feelings of acceptance and kindness towards themselves are influenced by acceptance and kindness from their immediate and broader environment (e.g., family members, friends, service providers, and community members). Stated in another way, social support, in the form of attitudes (e.g., non-judgemental, accepting), encouragement, and accompaniment, was considered by young people as key influences on their well-being. These findings converge with those of Uzenoff et al. (2010), who compared the predictors of psychological well-being among a first-episode psychosis sample.
with a non-clinical sample of their peers; results indicated that well-being was predicted by perceived social support.

It is known that being labelled with a psychiatric disorder presents a risk situation for the internalisation of stigma and consequent negative impact on psychological well-being (Norman, Windell, Lynch, & Manchanda, 2011). The present study provides insights into how youth manage stigma and negotiate its potentially adverse effects on their well-being. The findings suggest that normalizing-identity work enables youth to enhance their stigma resilience; that is, the capacity to withstand the negative effects of stigma on their wellbeing. This is achieved through narrative practices, activities, and supportive interactions that reduce their experiences of difference, increase their self-esteem/self-worth, and self-compassion.

**Shifting attention to the environment’s role in resilience**

*Discussion of key message 5: The availability, accessibility, and meaningfulness of resources from the social environment, structural environment, and technological environment have a key role in promoting and/or hindering young people's resilience.*

The present study responds to the call from contemporary resilience researchers (e.g., Bottrell, 2009; Ungar, 2012) who advocate for de-centering the responsibility of resilience from individuals to their physical and social ecologies. It supports and extends an emerging body of literature that has focused attention on the identification of social, cultural, and institutional processes that shape resilience through the distribution of well-being enhancing resources (Bottrell & Armstrong, 2012; Ungar, 2012). For example, the present findings illustrate how the identity work efforts of young people were constrained by their socio-economic and living circumstances. Three findings in particular, which are relevant for applied research, are discussed in the following passages.

*Accessing specialized services in the context of being homeless.* There is limited literature in which can be situated the fact that 41% of the young people in this study, that is, all of whom who were living in substandard housing conditions, were not receiving specialized early psychosis intervention services. This proportion of the sample, instead, received generic psychiatric and mental health social services within the context of a broader inner city YMHP.
While that program enabled five out of the seven youth to stay out of shelters and off the streets through provision of access to housing within SRO buildings, one could argue that these youth were nonetheless homeless given the substandard, congregated, and ghettoized conditions of the buildings (and neighbouring communities) that they were “placed” in (using Smiley’s word). This is not only substantiated by the youth’s voiced perspectives on their housing situations, but also based on the continuum notion of homelessness that suggests that homelessness is a socio-structural phenomenon that includes living in youth shelters, substandard housing, and spending a large proportion of one’s monthly income on housing (Frankish, Hwang, & Quantz, 2005). All three of these factors correspond well to the situations of 41% of the young people in this study and presented as barriers to their efforts and desires for enhanced well-being.

When compared to those recruited from the EPIP, young people living in substandard housing and youth shelters were less informed about their illness, more distressed regarding their housing situations, more symptomatic (anxiety, depressed mood, psychosis), faced greater challenges in terms of engaging in highly valued activities, and most (although importantly not all) were affected by ongoing substance abuse issues. They were also more estranged from family and less educated. Unstable housing conditions may contribute to the exacerbation of psychosis, or slow down time to symptom remission (thereby prolong the duration of untreated psychosis), and also have an effect on other co-morbidities such as substance abuse, all of which were observations noted in this study. As Smiley explained, she resorts to alcohol abuse as a way to cope with the stress of her housing situation, and as Philip emphasized, it is difficult to stay sober when one is literally surrounded by “trigger after trigger.” These participants were also exposed to intervention practices that are inconsistent with those used in specialized early psychosis intervention programs, such as contingency management to improve medication adherence and encourage participation in drug rehabilitation. In relation to the participants in the present study, these practices did not appear to be effective; for example, recall the account of Smiley, who stated that she was told if she completed an inpatient drug rehabilitation program, she would then be given support to access better housing.

In this context, contingency management refers to a verbal contracting system wherein upon completion of tasks or engagement in positive behaviours, patients are rewarded.
**Accessing peer support.** For those who had access to it, the opportunity to hear the stories of others, and share experiences with others in terms of psychosis and the process of recovery, was considered highly valuable by young people in this study, and contributed to their process of normalizing-identity work. This aspect of services stood out in the minds of young people among a gamut of other interventions received and as such is noteworthy. These findings converge with other work documented in the first episode psychosis literature. All participants in Fisher and Savin-Baden’s (2001) service evaluation study, for example, expressed the value of sharing their experiences with others. Perry et al.’s (2007) study identified that hearing about positive outcomes achieved by others from service providers contributed to participants’ experience of hope. More recently, Windell and Norman (2012) identified that relationships with peers within the psychiatric community contributed positively to young people’s process of recovery and were sources for: hope, reducing alienation, strategies for coping, and social connection. The present study sheds light on what aspects of these peer relations may be most salient for young people. The findings suggest that the opportunity to hear the psychosis and recovery stories of others (e.g., stories that convey the possibilities for a ‘normal’ life) reduces experiences of isolation and difference, and facilitates the process of normalizing-identity work. These findings may also be situated within the broader practice and literature base of peer support for individuals with mental illness (Davidson, Chinman, Sells, & Rowe, 2006).

**Tapping into technology.** The findings from the present study illustrate the important role of technology in participants’ lives, which transcended across socio-economic diversities within the sample. Technology enabled young people to access well-being enhancing experiences (e.g., connecting with others; calming/de-stressing), to share their accomplishments with others, and to cultivate and maintain extensions of their identity. In other words, Internet and mobile technologies, as mainstream objects and spaces, provided young people with opportunities to sustain, restore, and enhance their normal sense of self and identity. Moreover, a serendipitous finding of the study, resulting from the process of inquiry, as opposed to the questions of the inquiry, was that technology facilitated the work of this research process by facilitating contact with young people through texting, emailing, and also enabling young people to participate in the study through various ways (e.g., sending me digital photographs and writing, in relation to the study topic).
Given the popular nature of mobile, social media, and Internet technologies among youth, it is surprising that their roles in relation to service delivery have yet to be examined in the first episode psychosis literature. In a rare documented example, Killackey et al. (2011) report on their study protocol which involves harnessing mobile technologies and social media to deliver an exercise therapy program to young people recently diagnosed with first episode psychosis. They adopted mobile technologies and social media to promote social interactions which are hypothesized to help overcome motivational barriers associated with engaging in an exercise program. Such a program, for example, might be useful for someone like Kevin who spoke of the need for social support in relation to increasing physical activity in his life.

While the discussion and examination of e-mental health in the early psychosis literature is limited, within the broader sphere of mental health service delivery, a burgeoning field of e-mental health has emerged. For example, in 2009, the first international E-Mental Health summit was held in Amsterdam; subsequently, the Journal of Medical Internet Research published a special issue focused on presentations given at that summit. E-mental health is defined as: “mental health services and information delivered or enhanced through the Internet and related technologies” (Christensen, Griffiths, & Evans, 2002, p. 3). A review of the literature (Adair & Lal, 2012) reveals that the types of activities that occur within the spectrum of e-mental health can be categorized as follows: frontline delivery activities related to screening, mental health promotion and prevention, provision of treatment; training activities such as delivering continuing education to professionals; administrative related activities such as managing patient records; and research related activities, for example research databases and study management software. The popularized Internet and mobile technology landscape (including social media) provides fertile ground for the development and investigation of e-mental health interventions pertaining to the field of early psychosis. As such, future research that addresses any of the above areas is timely and warrants consideration.

**Discussion of the Findings in Relation to Implications for Practice**

Based on the findings, several implications for practice within the field of early psychosis intervention are considered in this section.
Facilitating identity work through multiple mediums of choice

Within the context of service provision for individuals with mental illness, Roe and Davidson (2005) asserted that “it is the narrating self and the construction of its ongoing story that must take, and remain centre stage” (p. 94). This assertion resonates with the present study wherein young people were observed to strive towards opportunities that enabled them to make sense of their experiences and sustain, restore, and enhance their identities. As such, I concur with others (e.g., Macnaughton, 2008) that young people’s narrating efforts should be supported. The sub-themes identified in the present study pertaining to the notions of self-esteem, self-compassion, and normality may also be relevant to consider within the context of facilitating identity work. The findings can help providers be more aware and have a better understanding of the types of narrative practices and strategies that young people use to negotiate a normal sense of self and identity in their interactions with others. The nuanced meanings that young people convey through their use of the term normal are also relevant to consider.

Additionally, this study highlights that identity work integrates two forms of actions, narrative practices and activity engagement. Moreover, it shows that identity work occurs inside and outside of traditional talk based activities of psychotherapy and psychoeducational interventions. In fact, young people’s accounts illustrate several mediums through which they engage in meaning-making and identity work, including art making, writing, listening to music, and participating in narrative oriented research. This converges with Sutton et al.’s (2012) conclusions which highlight the importance of exploring and expressing meaning through activity engagement as a key way of supporting recovery in the context of mental illness. Moreover, not only can meaning-making be facilitated within the context of patient-provider interactions and group interventions, it also can be supported through activity related opportunities within the context of a young person’s day to day environment.

The link between activity engagement, meaning-making, and identity work suggests an opportunity wherein the field of occupational therapy can contribute. Occupational therapists, working from an occupational science perspective (as opposed to a biomedical one) can place attention on meaningful activity engagement, not just from the performative, functional, and participatory perspective of doing activities, but also on meaning-making derivations from activities and their role in identity work. In this regard, I support the conceptual link previously
made by Christiansen (1999), but which is not necessarily practiced widely, between identity work and activity engagement, in the field of occupational therapy. For example, it may be worthwhile to identify with young people what activities they perceive as being highly valuable for their well-being through a process of exploration and prioritization (as was done in this study). Moreover, an exploration of the meanings and experiences derived from these activities (in addition to the extent to which they participate in these activities and what promotes and hinders their participation) is also suggested here to be a worthwhile endeavour. This exploration process may prove to be supportive of young people’s identity work and help providers identify areas for interventions. For example, following a mind mapping activity with Lily of the meaning of going to work, an activity she identified as being highly valuable for her well-being, she spontaneously noted to me: “Thank you, I found that was helpful. It made my values for work more clear for me.” Thus, the activity of mind mapping, in turn also became a meaningful one, because it enabled Lily to engage in a process of values clarification in relation to an activity that she engages in daily life (going to work).

Matching activities, environments, and interactions to a young person’s narrative needs is also relevant to consider. Roe and Davidson (2005) argue that it is important to recognize the complexity inherent in the process of facilitating meaning-making processes with patients. This rings particularly true in settings where biomedical discourse is hegemonic in its expression within psychiatric care and research. While it is important to note that biomedical discourse can be perceived and experienced as very helpful for some young people (e.g., see Larsen, 2007), for others, it can come into tension with, and run the risk of overshadowing, disengaging, disrupting, and even capsizing other potentially helpful processes of meaning-making. Thus, the delicate nature of how this can be addressed beyond information provision, with a more dialectic engagement and contextual attunement to a young person’s narrative process, within the context of his/her social circumstances, requires ongoing consideration by practitioners as well as researchers. The provision of psychoeducational interventions that match or meet young people’s varied needs, and the therapeutic skills of providers to support these needs, poses a human resource and system capacity challenge for service providers and system planners. Empowering young people with the freedom to enact their narrative process may be constrained at times by other commitments and responsibilities of service providers, as well as lack of human resources and skills training in this area. There is potentially a taken for granted tension that lives herein
between support for the idea of helping young people construct an adaptive narrative of their experiences, and the actual actions engaged in, or the capacity to do so effectively.

As a starting point for further reflection and investigation, Lysaker and Buck (2006) suggest the following principles to keep in mind for the process of supporting narrative processes: engaging in a non-hierarchical dialogue in which explanatory models are not imposed, and engaging in a conversation that elicits individuals’ understandings of past, present, and desired futures, and how to get there. This has implications to consider in relation to how psychoeducation is currently delivered in early psychosis programs, wherein there is a tendency to focus on a biomedical system of explanation. Interventions have also been developed within the first episode psychosis field which address identity work in relation to stigma and illness understanding; some show promising results (e.g., McCay et al., 2006), albeit more research is needed in this area.

In the present study, the opportunity to share stories of psychosis and recovery with peers having gone through similar experiences stood out as a key health service related contributor to young people’s well-being in this regard. The value of such opportunities, as discussed earlier in this chapter, is supported within the broader mental health peer support literature (e.g., Davidson et al., 2006). However, there is also the challenge of making such opportunities accessible to young people; some may not be willing or able to attend groups in which peer support is provided. The present study also highlights the importance of extending therapeutic attention on identity work outside the traditional clinical setting. Thus, other ways through which peer support can be offered could be considered, for example through technological means. These findings may inform the planning, development, and implementation of psychosocial services, which can sometimes be monopolized by the activity of providing information on psychosis and treatment through presentations, videos, and pamphlets; leaving little time and opportunity for young people to exchange stories and moments of support among themselves. The present study also illustrates how narrative processes are integrated, enacted, hindered, and facilitated in the context of young people’s daily lives through activity engagement and interactions with others.

**Exploring well-being therapy for early psychosis intervention**
Within the broader field of positive psychology, a number of well-being interventions have been developed and empirically tested. These therapies address some of the themes identified in the participants’ accounts such as cultivating virtues and positive thinking. As such, the potential inclusion of well-being interventions within the gamut of psychosocial interventions, delivered to youth recently diagnosed with psychosis, warrants further examination and consideration. The potential benefit of well-being therapy for the first episode psychosis population has also recently been expressed by Uzenoff et al. (2010).

Martin Seligman has been pioneering the development and testing of interventions intended to enhance positive mental health and well-being in the general population within the field of positive psychology. Such interventions address, for example, processes of building gratitude, and increasing awareness of personal attributes and strengths. The interventions are done within the context of individuals’ daily lives as opposed to within a therapeutic interaction with a service provider. For example, in a general population sample, randomly-assigned, placebo controlled Internet study, Seligman, Steen, Park, and Peterson (2005) found that moderate to higher effect sizes were maintained up to six months on scales measuring experienced pleasure, engagement in activities, and engagement in meaningful activities for interventions that focused on positive aspects of one’s daily life and the conscious daily application of a personalized character strengths inventory.

It may be useful to consider adapting and empirically testing well-being interventions for their utility in the context of providing services to the first episode psychosis population. In fact, the approaches, principles, and interventions within the positive psychology field (a field originally intended for the general population) have already started to be integrated within psychiatric rehabilitation contexts. For example, Resnick and Rosenheck (2006) anecdotally report that engaging individuals with mental illness in the process of completing a strengths survey that integrates the virtues of wisdom and knowledge, courage, humanity, justice, temperance, and transcendence produces benefits such as a sense of accomplishment and mood enhancement simply from completing the assessment. They also observed that individuals, who completed the survey and received results on their signature strengths, used these strengths as reminders of their abilities to cope with subsequent challenges they encountered. Indeed, the present study illustrates that young people naturally gravitate towards activities that enable them to cultivate their skills, strengths, and virtues. These findings combined with previous work have
implications for the importance of narrative, interactional, and ecological interventions facilitating reflection of, and supporting cultivation and enactment of personal strengths and virtues in young people. The intention of such a focus on well-being, however, does not intend to dismiss the unquestionable suffering that many young people experience in the face psychosis and its psychosocial consequences, nor to stop efforts in addressing social and structural aspects of the environment that contribute to the negative consequences they experience (e.g., stigma).

**Turning towards the ‘have nots’ of specialized early psychosis services**

“...In every country in the world the key mental health challenge we face is one of undertreatment...” (McGorry, 2012)

Undertreatment, from the perspective of the present study’s findings, can be conceptualized as lacking structural access to specialized services for early psychosis within the context of homelessness and structural inequities (e.g., poverty; living in substandard housing and youth shelters). While the issue of homelessness is relatively absent from the early psychosis intervention literature, the present study suggests that the issue should not be moot. This study provides evidence which suggests that within Canadian urban settings, there may be a proportion of young people affected by psychosis, experiencing housing instability, and who may not be accessing specialized services that meet their complex needs. In the context of undertreatment, the structural access, or rather lack thereof, to specialized early psychosis interventions for young people living in youth shelters and substandard housing warrants attention from service providers and decision makers. As a group, the young people recruited from the YMHP represented a more complex, multiple morbidity picture than the group recruited from the EPIP. Where a population seems most in need of services, they seem in this case to be the least served from all corners concerned.

These findings highlight, at the minimum, an area that warrants further attention from the policy, research, and practice arenas: the interface between homelessness (and associated structural factors, such as poverty, lower levels of education), access to specialized early psychosis services, and recovery in early psychosis. There may be justification for exploration of a three pronged intervention approach. First, a housing first model (e.g., see Tsemberis, Kent, & Respress, 2012) could be considered in which young people are provided with reasonable
choices for access to housing, that is, where they are not subjected to being ghettoized and congregated in substandard settings unless that is their claimed choice (which was not the case for any of the participants in this study). Research on such an approach indicates that individuals with co-morbid psychiatric and substance abuse concerns can make improvements in both areas within 2 years of being provided with stable housing. Moreover, this is achieved without placing contingency demands for abstinence or treatment compliance before providing access to appropriate housing. Second, a re-consideration of how early psychosis services in collaboration with housing and support services are organized and delivered for this subgroup of young people expressing particularly complex needs is warranted. This may include interagency and intersectoral collaborations to facilitate simultaneous access to appropriate housing conditions, evidence based substance abuse harm reduction, community based clinical case management, and meaningful activity engagement. Third, it is important to increase the capacity of clinicians in being able to adequately address youth experiencing a first episode of psychosis who are also entrenched within the context of drug abuse and poverty.

**Considering the potentially paradoxical effects of service provision**

The findings from the present study illustrate how young people’s efforts at sustaining, restoring, and enhancing their normal sense of self and identity are influenced by the service environment in positive and paradoxically negative ways. This was illustrated particularly through young people’s experiences of engulfment, ghettoization, regulation, and disconnection in relation to the services and supports they received. The accounts demonstrate that while services have the capacity to provide meaningful health, social, leisure, and vocational opportunities for young people, they also have the unintended capacity to reinforce young people’s experiences of difference and abnormality and ultimately counteract their process of resilience. Conversely, it should also be noted that some young people in this study expressed being at ease in the same settings that were expressed and experienced by others as being inhibitory to their well-being. Those who adopted an embracing approach to narrating their identity in relation to illness were more likely to be in the former group. These findings suggest the need for further consideration of young people’s experiences of services in general and potentially also in relation to their narrative practices.
Discussion of the Findings in Relation to Implications for Future Research

This study provides insights in terms of how young people engage in the process of identity work. This identity work, argued here to be a pathway of resilience, is cumulatively captured through narrative practices and engagement in highly valued activities. It provides a framework for future research that seeks to inform how resilience enhancing identity work efforts of young people can be studied and leveraged in the context of their daily lives. The subtext of normality, based on this study, and previous qualitative work, is an area worthy of further discussion, examination, and deconstruction particularly in relation to services, mental health, identity work, and well-being. While this study provides insights into how young people negotiate a normal sense of self and their well-being in the context of being labelled with a disorder associated with stigma, these insights could be further examined longitudinally and across contexts. For example, to what extent do narrative strategies employed by youth recently diagnosed with psychosis (e.g., distancing, embracing, abstaining, and reducing over-identification) evolve over time, and what else can be known of their relationship to resilience? If they do evolve, what factors contribute to this evolution? Additionally, how do health care providers respond to these different types of strategies? Do providers support or hinder them? Do they privilege some strategies over others? Furthermore, how do providers respond to young people’s notions of normality?

It is recognized that people with mental illness should be empowered to “develop their own stories of themselves” (p. 30); however, effective ways in which this can be done are yet to be identified (Lysaker & Buck, 2006). Research on how resilience enhancing narrative processes could best be facilitated in the context of patient-provider interactions, group interventions, and patients’ natural environments warrants further attention. This study illustrated that one way in which the narrative process of meaning-making is facilitated, is through the sharing of psychosis and recovery stories with peers having gone through similar experiences. It may be that the peer support aspect, and specifically the listening to, and telling of stories of psychosis and recovery is a key ingredient that contributes to the success of group psychoeducation interventions; this is a hypothesis that warrants further investigation. Peer support is an under-researched area as it pertains to individuals with mental illness (Davidson et al., 2006), particularly within the context
of first episode psychosis. According to Davidson et al., peer support “is based on the belief
that people who have faced, endured, and overcome adversity can offer useful support,
encouragement, hope, and perhaps mentorship to others facing similar situations” (p. 443). There
are several models of peer support that have been developed, and further research is required to
help determine which approaches (and which components) are most effective for the first
episode psychosis population.

The relationship between activity engagement and well-being could also be further
examined within the context of research in early psychosis. Thus, in addition to common
measures of function which assess the extent to which individuals are engaged in productive and
leisure activities, researchers might also consider addressing the extent to which these activities
provide meaningful levels of valued engagement. Building on Waterman’s (1993) work, for
example, such measures might include eliciting from respondents activities they engage in and/or
would like to engage in that they consider as being highly important for their well-being, and
examine the extent to which these activities engender eudaimonic and/or hedonic well-being, as
well as identify the barriers and facilitators to such activity engagement. Results may be
considered in relation to symptoms, relapse rates, substance abuse, and other broader functional
outcomes.

The present study highlights that a proportion of young people recently diagnosed with
psychosis are not adequately housed, nor do they have access to a comprehensive set of
psychosocial and medical services. The potential risk factors associated with youth finding
themselves in such situations (e.g., substance abuse, lack of education, limited support networks)
and the symptomatic, functional, and well-being ramifications for this subset of the population
are illustrated by young people’s narrative accounts. This issue, from an epidemiological
perspective has been poorly addressed in the literature. However, studies do suggest high rates of
psychosis in homeless youth in the range of 25% (e.g., Herrman, McGorry, Bennett, & Singh,
1990). It is unclear what proportion of street youth in Canada experience a first episode of
psychosis and continuously lack access to specialized services. This type of information would
be useful for service planning and allocation of resources. Further investigation is also needed on

46 This appears to be changing however; for example, Robinson et al. (2010) recently documented a study protocol
of a randomized control designed to examine the feasibility and effects of a peer support program following being
discharged from specialized early psychosis services.
what are the best models of service delivery (which potentially integrate early psychosis services with public health sectors of housing and employment) to address this complex needs population.

**Study Strengths and Limitations**

The strengths\(^{47}\) of this study centre on the unique research design, which is not characteristic of previous related work in this area. First, this study adopted a novel approach to purposive sampling through recruitment of youth recently diagnosed with psychosis from two different sites. As a result of the purposive sampling strategy, the sample is diverse in terms of ethnicity, socio-economic background, substance use/abuse history, education, employment, and living situations. Second, the research design incorporated methods that allowed for prolonged engagement and reflexivity, strategies that are recognized in qualitative research to enhance credibility and trustworthiness of findings. Specifically, the methodology allowed for multiple interviews; as a result, all but three participants were seen two times, and several of the young people were seen up to five times over the period of one year. This allowed for the researcher to develop rapport, explore a range of topical areas, and observe a saturation of themes across multiple interviews with the same participants and across participants. As a result, in-depth and rich responses can be observed through the lengthy nature of the interviews and resulting transcripts ranging between 25-60 pages. Third, the research design adopted the strategies of methodological triangulation and methodological crystallization, approaches that are considered to facilitate rigour and credibility of qualitative research findings. In this regard, several data collection methods were used, including individual interviews, photography, focus groups, and mind maps. This allowed for the observation of convergence and divergence of themes across data sources. Fourth, the study is not restricted to a group of participants that are highly functional or particularly engaged in treatment services especially when considering the sample recruited from the inner city YMHP. Fifth, throughout the analysis process, codes and emerging categories of concepts and processes were discussed with the researcher’s supervisory committee members. In particular, the primary supervisor listened to and coded 25% of the preliminary data set (e.g., first interviews), and instances of coding convergence and divergence were compared and discussed. Subsequently, theoretical categories and sub-processes were discussed with

\(^{47}\) Other examples pertaining to the strengths of the study are discussed in the quality appraisal section of Chapter 2.
approximately 30% of the sample through member reflection interviews, supplemented by feedback from committee members on drafts of memos and findings. Sixth, coherence can be observed between various aspects of the study, such as the methodological framework and the way in which data collection and analysis ensued (e.g., consistent with grounded theory, coding and constant comparative methods were used; consistent with narrative inquiry, the performative aspects of participant accounts were attended to); and, the methodological framework and the way in which findings are represented (e.g., attention to the common, situated, and particular).

This study also has several limitations that should be acknowledged. First, the small sample size of 17 participants restricts the possibility for results to be generalized. However, it is important to note that the purpose was rather to illustrate what types of processes may be involved in resilience that warrant further research and consideration. Indeed, my intention is not to make claims regarding the generalizability of the findings. Nonetheless, a small sample size increases the possibility that there may be experiences and perspectives of young people recently diagnosed with psychosis that are not represented here. In a related second point, the sampling strategy, while having some benefits, excluded individuals who may have dropped out of treatment very early or who were unwilling to discuss their experiences. Indeed, two male youth who were approached for the study, refused to participate following the consent form review meeting. Third, despite attempts to increase the ways through which youth could participate in the present study, these were qualitative in nature, and as such may have been a deterrent in the recruitment process. For example, one of the males who refused to participate stated that his main reason was that he did not feel “verbal” enough to contribute meaningfully to the study. It seemed he would have been more inclined to participate if the study simply involved completion of questionnaires. Fourth, given that only a portion of the sample (35%) was followed over a period of one year, this limited my ability to prospectively consider how time was a confounding factor on the processes explicated in the findings.
Concluding Remarks

A journey of a thousand miles begins with a single step (Lao Tzu)

I embarked on this journey to develop research skills to enable me to ‘give voice’ to the diverse experiences and perspectives of young people recently diagnosed with psychosis, with the ultimate aim of improving services offered to them. This learning process has contributed understanding to how young people sustain, restore, and enhance their resilience based on an elicitation of, and engagement with their narrative accounts. A fundamental question that I asked participants at the end of our meetings was: “what advice would you give that could be helpful to health care professionals and other young people who have gone through similar experiences as yourself?” Thus, to conclude, the following epilogue re-presents their individual responses through a compilation of poems using the method of found poetry. This epilogue highlights key themes explicated in the findings of the dissertation, re-presented in an alternative form, through which the process of resilience can be understood. I believe it is most appropriate to end this dissertation with their voices in focus, at front, and centre-stage.
EPILOGUE

If it Could be Different,
In a way that Would be Helpful,
What Advice would you Give?
To other Young People?

~

I don’t know,
I don’t know,
If I’m In Any Position,
To be Giving Any One Advice.

*

That's a good question.

*

A tough question.

*

I don’t know,
I don’t know,
What would I say?
Oh my god!
No,
Let me think.

*

---

48 This compilation of poems has been developed through the method of found poetry. This involved using words from the responses of each participant to construct a poem. The responses of twelve participants are represented here. A methodological example of the process through which the poems were constructed is provided in Appendix E. The star symbol (*) in the text represents the end of one participant’s response and marks the beginning of another’s. The tilde (~) is used here to indicate a separation between the interviewer’s question and a participant’s responses.
Believe in yourself.
You’re awesome,
You’re good,
You’re a good person,
Don’t listen to those voices.

Believe in yourself.
Don’t believe in what everyone,
Made you believe,
Think positive.

Believe in yourself,
You’re still capable,
You can do what you want,
Don’t depend on other people,
For your happiness.

Believe in yourself,
Don’t let your past dictate,
Where you are now.

Believe in yourself,
Focus on you,
Know that someone does
Love you
That’s why you were born,

Believe in yourself.

*

In time,
If you do the right things,
It can go away.

No one’s actually
Reading your mind,
It might feel that way.

It’s not really true,
They will verify that for you,
If you ask them in the right way.

They’ll say,
‘No, I’ve never heard your thoughts before.
That’s the biggest step
I had to take.
I’m not really Telepathic,
‘It’s all in my head,’
I say.

A biochemical imbalance,
If treated the right way,
Can go away,
They’re just symptoms.

That’s what I’d say.

*

Live your dreams.
And don’t give up.
Accept yourself,
For who you are.

Have faith in yourself,
Have faith in what you’re doing.

Have someone to talk to
No matter when,
24/7,
Someone
That you can count on,
A hotline, a person.

Follow your dreams.
Follow things,
That can distract you,
From things

*

Take a paper and a pen,
Write down your favorite ten,
People that you know,
Your mom, your dad, your best friend,

Write them all a letter.
Call them, or meet them
Just get in touch with them.

Find a few hobbies.
Write down your favorite three.
Exercise. Eat healthy.
Sleeping is so Key.

Find Expressive Outlets,
Drawing, writing, music, or whatever
Be in tune with your surroundings.
Life is connected wherever.

And That Psychosis –
Might not have been enjoyable,
Or good for your brain,

But you're here now,
And you're alive
So that Challenge
Or that Pain
Can help you move Stronger

And, most importantly,
You're blessed.

* 

We're all different,
You have to find,
Your own advice,
Your own strategies,
To deal with it,
Because everybody's
Psychosis,
Is different.

~

And what would you say to other people,
On how best to help young people,
With similar experiences as you?

~

I don’t know,
What could I say?

* 

I don’t know,
They probably have
Better advice than me.


* How to word it?
   I know it-
   But, to word it.

* Let me think about this.

*

Don't just say,
‘Don't do crystal meth, or crack,
Don't smoke too much pot’
Find activities that are interesting too –
To connect that advice to,
Do something
Constructive with them,
It’s probably the best bet.

*

The youth worker I have,
   She's really nice.
She helps in a lot of ways,
I wouldn't give her any advice.
   Support young people,
In the way they want in life.
Just try to support them,
   In changing their lives.

*

Keep asking,
Whether the support,
   You're giving,
Is the right support.
That what you're delivering,
   Is actually helpful.

And Try not to Alienate,
Whatever you ask or say,
   You're impatient,
You show,
You can't understand,
It's so easy to alienate,

How are you going to help them
If they think, you think
That they're
Bothersome
Annoying, a Burden,
Annoying, Like, Hopeless.

I'm just being honest.

Always have a smile on your face.
Try to Encourage them
To think that every mistake
That they make
Is an opportunity to Grow.

Convey that feeling that,
Everything's okay.
Feeling embarrassed is okay,
To be sad, to be angry, to cry, or to be confused
Is okay.

All these things are going to change.
That's the most important thing,
People get so discouraged
Because they think
They've made no progress
Or they're going
To make no progress

They've got to see the light,
If you can give them
A Vision of the light,

Then,
It's, like,
Tangible

* *

There should be a transition,
From mental illness
And learning to cope,
To connect that person
With society.

I’m finding it hard to get outside
Of mental illness,
I just want to do it,
Already;
Function in society.

I see people downtown, Doing,
They’re taking courses, they’re working,
Going, or travelling.
I want to do that normal stuff,
And mental illness is annoying.

The people say,
Why don’t you do it?
Why don’t you go to school?
Look for work,
Do something.

~

So, if there was some kind of
Transition space,
Some kind of transition,
To keep you moving,

~

I just wish it was right away,
Like a cigarette,
Or Something

So I was thinking,
What’s holding you back?
You can make your Own
Mental health thing,

Once you’ve got your job,
Your kids, your career,
You feel like your own doctor,
You can handle your life,
I want to do that.
And what helps with the transition?

During the transition,
Tiny things help, that’s all,
To keep a level of patience,
Like hang out with a friend,
Watch a movie,
Not involved with protocols,
Little things, little outings;
Conventional things, that’s all.

* 

Hard to take,
How they Deal with you.
How they Give advice
Try to Relate with you.
Would be better
If they Straight Up
Honestly
Told me,
What was wrong with me,
How to deal with it
Not beat-around-the-bush
Psychology things,
Asking me questions
Just to get this one thing
Out of me.
If they Just asked me
Straightforward,
That'd be better.

* 

They put people in shitty housing,
And there’s a bunch of places like that,
They put us in shitty places,
Because there are people like that.

They put people in those buildings,
‘Get rid of the problem.’
They just put people there, and
Deal with the problem.
I’m not a crackhead or a junkie.
It’s pretty much the same guests I have,
We just hang out,
It’s not a crack house or anything like that.

It’s kind of hard; it’s true.
For some people,
It’s going to be crazy,
If they don’t have those rules.

I got put in that place
So they kind of know how I am,
They shouldn’t put me in places like that.

*

Understand,
Learn,
Discuss,
Get to Know,
Get Involved,
Be Personable,
With their patients.

*

Listen,
Ask,
Engage.

*

Don’t think you know
Better than I do.

Listen to me,
I know what’s good for me,

I may be feeling things,
That you’ve never felt before,
Please try to understand.
I maybe do life a little differently.

I expect people to behave well,
To treat me well,
Maybe I’m a person with special needs,
But Please,
Don’t Label me,
You’re making it harder on me
Just treat me well,
Listen to me.
REFERENCES


reflective writing. *Academic Medicine, 84*, 587-596. doi: 10.1097/ACM.0b013e31819f6ecc


American Journal of Orthopsychiatry, 76, 395–402. doi: 10.1037/0002-9432.76.3.395
Educational Action Research, 14, 187–201. doi: 10.1080/09650790600718035


### Appendix A: Social and demographic information form

**Demographic Information Form**

Resilience in Early Psychosis

Date: _______________

First name: ____________________  Last name: ____________________

Mailing address: ______________________________________________

Phone number: ____________________  Email address: ____________________

Primary mental health care provider name and contact information: ____________________

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Place of birth</th>
<th>Check all that apply:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Canadian</td>
</tr>
<tr>
<td></td>
<td>American</td>
</tr>
<tr>
<td></td>
<td>Aboriginal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Countries parents born in</th>
<th>Mother</th>
<th>Father</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>___________</td>
<td>___________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current living situation</th>
<th>Living with Parents or Legal Guardian</th>
<th>Living by self</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Living in supported Housing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other living situation</td>
<td>Describe</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current employment or education status</th>
<th>Check all that apply:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I’m currently employed</td>
</tr>
<tr>
<td></td>
<td>I’m currently going to school</td>
</tr>
<tr>
<td></td>
<td>I’m currently attending another type of program</td>
</tr>
<tr>
<td></td>
<td>I’m enrolled in high school</td>
</tr>
<tr>
<td>Previous education</td>
<td>I’m in year ________</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Years of Schooling Completed in High School</td>
<td>________</td>
</tr>
<tr>
<td>Years of Schooling Completed in College</td>
<td>________</td>
</tr>
<tr>
<td>Years of Schooling Completed in University</td>
<td>________</td>
</tr>
<tr>
<td>Degree/Diploma</td>
<td>Year</td>
</tr>
<tr>
<td>____________________________________</td>
<td>________</td>
</tr>
<tr>
<td>____________________________________</td>
<td>________</td>
</tr>
<tr>
<td>Household income</td>
<td>/Year</td>
</tr>
<tr>
<td>Children</td>
<td>Number of children: ________ Age of children: ________</td>
</tr>
<tr>
<td>Services use and reasons for using these services</td>
<td>I access services at the following programs/organizations:</td>
</tr>
<tr>
<td></td>
<td>___________________ how often ________ since when ________</td>
</tr>
<tr>
<td></td>
<td>Reasons: ___________________ how often ________ since when ________</td>
</tr>
<tr>
<td></td>
<td>___________________ how often ________ since when ________</td>
</tr>
<tr>
<td></td>
<td>Reasons: ___________________</td>
</tr>
<tr>
<td></td>
<td>___________________ how often ________ since when ________</td>
</tr>
<tr>
<td></td>
<td>Reasons: ___________________</td>
</tr>
</tbody>
</table>

Thank you for taking the time to complete this form
Appendix B: Consent to be contacted form

THE UNIVERSITY OF BRITISH COLUMBIA

CONSENT TO BE CONTACTED

Dear ________________.

My name is Shalini Lal and I am a PhD student at the University of British Columbia. I am conducting a study about resilience, in other words, overcoming challenges in life. The goal of the study is to better understand the unique perspectives of young people who have experienced symptoms of psychosis in the past three years.

You are invited to participate in this study. The study involves participating in interviews and creative activities such as taking pictures with a camera, drawing, writing, or other forms of art work depending on your preference. In the interviews, I will ask you about your perspectives on: what aspects of your life are important for your well being; what kinds of challenges you face (related to school, work, family, peers, recreation, self care, or other); how you respond to these challenges; and what kinds of activities and/or what aspects of the environment (e.g. community or health services, family, peers) help (or hinder) your ability to cope.

Your ideas about what needs to change (or stay the same) to help other young people in similar situations are important to understanding how services in the community can be improved to support the resilience of young people who have experienced psychosis. That is why you have been invited to take part in this study and share your ideas.

You are free to withdraw from the study at any time and are also free to decline any of the activities suggested at any time and this will not affect the mental health services you receive in any way. All identifying information from the study will be kept strictly confidential.

As a token of appreciation for your contribution and/or to make up for costs of things such as transportation and inconvenience, you will receive a $20.00 honorarium in the form of a gift card (or 8 TransLink bus tickets) at the beginning of each interview meeting. There are 6 meetings related to the study, therefore you will receive a total of 6 gift cards if you choose to participate in all of them. Gift cards will be for clothing, food, or household stores in the lower mainland such as London Drugs, Safeway or Army & Navy.
How Can I Find Out More?

If you are interested to find out more about this study, please complete this form and return it to the secretary or a team member at ____________ (recruitment site).

I will then contact you to provide you with further information about the study and answer any questions you might have. Please keep the first two pages of this form for your own information.

If you prefer, you can also contact me directly by telephone at (phone number) or by email at (email address).

Thank you for taking the time to review the information on this form.

Sincerely,

Shalini Lal
University of British Columbia
(phone number)

Melinda Suto
University of British Columbia
(phone number)

I am signing this form to indicate that I agree for the student researcher, Shalini Lal, to contact me so that I can learn more about this study.

My Name: ________________________________

Signature: ________________________________

Phone: ________________________________

Email: ________________________________

The best way to reach me is by: ____________

A good day and time to reach me is: ____________
Appendix C: Participant consent form

PARTICIPANT CONSENT FORM

Resilience in Early Psychosis

Principal Investigator

Melinda Suto, PhD., Assistant Professor, Department of Occupational Science and Occupational Therapy, Faculty of Medicine, The University of British Columbia (UBC), (phone number)

Co-Investigators

Shalini Lal, Doctoral Candidate, Rehabilitation Sciences Research Graduate Program, Faculty of Medicine, UBC, (phone number)

James Frankish, PhD., Professor, School of Population and Public Health, UBC, (phone number)

Carl Leggo, PhD., Professor, Faculty of Education, UBC, (phone number)

Introduction

My name is Shalini Lal and I am a PhD student at the University of British Columbia. You are being invited to participate in a study that I am conducting. This research study is part of my Ph.D. degree. My supervisor at the University of British Columbia, Dr. Melinda Suto, will oversee my work.

What is this study about?

The purpose of this study is to better understand how young people who have experienced symptoms of psychosis in the past three years develop their ability to cope with adversities (challenges in life) and how the environment influences their ability to cope. You are being
asked to participate because we want to understand the unique perspectives of young people who have been diagnosed with psychosis in the last three years.

Basically, we want to understand your perspectives on what aspects of your life are important for your health and well being; and, your perspectives on the challenges you face (related to school, work, family, peers, recreation, self care, or other), how you respond to these challenges, and what kinds of activities and/or what aspects of the environment (e.g. community or health services, family, peers) help (or hinder) your ability to cope.

Your ideas about what needs to change (or stay the same) to help other young people in similar situations are important. Your ideas will help us understand how services in the community can be improved to support the resilience of young people who have experienced psychosis. That is why you have been invited to take part in this study and share your ideas.

**What will the study involve?**

Participation in this study will involve two individual interviews and an activity called photovoice. You are free to withdraw from the study at any time and are also free to decline any of the study activities at any time without jeopardizing the mental health services that you receive in any way.

**Individual Interviews**

You will first be asked to participate in two individual interviews with me at a time that is convenient for you. The location of these meetings will be at ___________ (recruitment site) or a quiet public area (e.g. a coffee shop or meeting room in a library) depending on your choice. Each of these interviews will last approximately 1-1.5 hours. Two 5 minute breaks will be scheduled during each interview; however, you can take more breaks as needed.

At the beginning of the first interview, I will ask you to complete a basic information form. I will be available to provide any assistance you might need to complete this form. The form will ask you questions like: what is your age, what is your living situation, what is your employment or education status, and the kinds of services in the community that you use. This information will be used to gain a better understanding about the general background of the people who participated in the study. You can decide not to answer any of the questions if you wish.

After this, I will ask you to describe a typical day including the kinds of activities you do to spend time and the places where you spend time in. Materials for drawing (e.g. paper, pastels, markers) will be available to draw a daily time line or visual map of spaces and places that you consider to be important. You will not be obligated to use these materials. I will also ask you to describe what kinds of challenges (i.e. obstacles or adversities) you are faced with and how you respond to these challenges in helpful ways (as well as not so helpful ways).

The second interview will be scheduled a week after the first interview. For the second interview, I will ask you to bring in something that you have created or written (e.g. drawing, lyrics to a song, piece of music, any form of writing, other) that represents activities that you find helpful (and not so helpful) for your health and well being. Materials will be provided for you to
take home if you would like to work on this activity. If you prefer not to draw or write, you could collect something already created (e.g. picture from a magazine, lyrics to song, a short story, or a photograph) instead. I will ask you to tell me about the art work or object you bring to the second interview. With your permission, I will also take a photograph of the art work/object.

Once we have finished the two interviews, I will ask if you would like to continue on with the second part of the study which involves an activity called photovoice.

*Photovoice (modified)*

In this activity, you will be given a digital camera to take home and will be asked to take pictures that describe how the environment and the services you use support or hinder your ability to cope with challenges in life. You will also be asked to take pictures that describe what needs to change (or stay the same) in the environment to help young people in similar situations as yourself develop their ability to cope with the challenges they face. Before doing this, we will meet with 3-5 other young people in the study to discuss the initial findings from the study and to talk about photography. We will go over basic photography techniques and talk about issues related to taking pictures. For example, to respect your privacy and the privacy of others, I will ask you not to take pictures of people and of yourself. You will have one week to take pictures and then I will develop the photos. I will then ask you to choose 4 photos that you would like to share with the group of other participants and to write 2-3 sentences about each of these photos. You will have the opportunity to keep a copy of your photos. The photovoice activity will involve 4 meetings; each meeting will last 90 minutes.

In addition to the individual interviews and photovoice meetings, I may ask to follow up with you to ask some additional questions and/or to get your feedback regarding my analysis of the information gathered during the study. This follow up would be through the telephone or an in-person meeting depending on your preference and you are welcome to decline this additional interaction.

Participating in all the activities related to this study will require about 15 hours of your time over 6-9 months.

**What are the risks of participating?**

There is a small possibility that participation in this study may cause some distress and discomfort as you reflect upon your experiences. There is also a small possibility of experiencing some regret about disclosing certain opinions or experiences during or after involvement in the study. To reduce these risks, you can choose to speak only about topics you feel most comfortable talking about. At any time you can request that parts of the interview or meetings not be used in the study. A list of resources will be provided to you for support in case you do experience some distress. I will help you to contact your primary mental health care provider in the event you do become distressed and are unable to continue participation in the study.
How might participation be beneficial?

You are being asked to participate in this study so that your experiences may be used to improve services for young people recently diagnosed with psychosis. The knowledge gained through the study may also be of use to you personally. For example, you may find that talking about your experiences with someone who is truly interested in hearing your story may bring new insights and understanding about the challenges you face, the strengths and resources you have, and your ability to overcome adversity. You might also enjoy engaging in the creative and social aspects that some of the activities in this study involve (e.g. photography, meeting with other young people). During the photovoice meetings, you will also be invited to share your feedback regarding the initial findings of the study and will receive a summary report of the photovoice meetings. You will also be offered a summary of the findings from the study once it is completed.

How can I be sure that what I say is confidential?

With your permission, I will audio-record the interviews and group meetings. These audio-recordings will then be transcribed. The audio files will be destroyed once they have been transcribed. Your name or the name of any other person you discussed in the interviews will not be transcribed and will not appear in any reports. Instead, you will be identified by a pseudonym (name that is different from yours) in all notes and transcripts. Also, no other information that could identify you will be included in the research reports. All identifying information from the study will be kept strictly confidential. Data will be kept in a locked filing cabinet at the University of British Columbia and digital files will be password protected. You can review and change any of the information you give me.

As part of this study involves discussions with others (photovoice meetings) I cannot guarantee complete confidentiality in those settings. However, I will take all possible measures to ensure confidentiality including asking all participants to respect each other’s privacy and to not repeat outside of the group what is said during the discussions.

How will the results be presented?

The results of the study will appear in written form in my doctoral thesis. I will provide you with information about how to obtain this report which will be a publicly available document. The results may also be published in journal articles or presented at conferences. You will be offered a summary of the findings.

Will I be compensated for my participation?

As a token of appreciation for your contribution and to make up for the costs of transportation or inconvenience, you will receive a $20.00 honorarium in the form of a gift card (or 8 TransLink bus tickets) at the beginning of each interview. You will receive a total of 6 gift cards if you choose to participate in all the interviews and photovoice meetings. Gift cards will be for
clothing, food, or household stores in the lower mainland such as London Drugs, Safeway, or Army & Navy.

What if I have any further questions about the study?

If you have any questions about the study, I will be happy to discuss them with you and explain anything that is unclear. Please call me, Shalini, at (phone number). Dr. Suto, my supervisor, can also answer any questions you may have by phone (phone number).

What if I have concerns regarding treatment and rights as a research participant?

If you have any concerns regarding your treatment and rights as a research participant, you may contact the Research Subject Information Line. This resource is located at the Office of Research Services at UBC. The telephone number is (phone number). The email is RSIL@ors.ubc.ca
Consent

Please note that participation in this study is entirely voluntary. You may refuse to participate in this study or withdraw from this study at any time without affecting the services you receive at _________________ (recruitment site).

Before signing, please check the following which apply:

☐ I have read and understood this information and consent form.
☐ I have had sufficient time to consider the information provided.
☐ I have had the opportunity to ask questions and have had satisfactory responses to my questions.
☐ I understand that all of the information collected by the researcher will be kept confidential and that the results will only be used for scientific objectives.
☐ I have read this form and I freely consent to participate in this study.
☐ I would like to be informed of the results of this study.

Your signature below indicates that you agree to participate in this study and that you have received a copy of this consent form for your own records.

Participant: __________________________

Please Print Name: __________________________

Date: ______________________

Contact Information: __________________________

Copies to: 1) Participant 2) AND study file
Appendix D: Illustration of a participant thematic map
## Appendix E: Example of process used to construct found poetry

<table>
<thead>
<tr>
<th>EXCERPT VERBATIM FROM TRANSCRIPT</th>
<th>DISTILLATION OF MEANING</th>
<th>POETIC REPRESENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>P13 Int2 Final.docx - 25:3 [R: Okay. And what advice would...] (691:748) (Super)</td>
<td>Keep asking, Whether the support, You're giving, Is the right support. That what you're delivering, Is actually helpful.</td>
<td>Keep asking, Whether the support, You're giving, Is the right support. That what you're delivering, Is actually helpful. And Try not to Alienate, Whatever you ask or say, You're impatient, You show, You can't understand, It's so easy to alienate, How are you going to help them If they think, you think That they're Bothersome Annoying, a Burden, Annoying, Like, Hopeless. I'm just being honest. Always have a smile on your face. Try to Encourage them To think that every mistake That they make</td>
</tr>
<tr>
<td>Codes: [Advice to Others-Supports]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No memos</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R: Okay. And what advice would you give to others -- so others who are, sort of, helping or supporting those young people? What kind of advice do you think you could give them so that they could provide support and help in better ways? P13: Yeah. Um, I guess, um, yeah, to always keep asking whether, you know, whether the support that you're giving is - - is the right support.</td>
<td>Keep asking, Whether the support, You're giving, Is the right support.</td>
<td></td>
</tr>
<tr>
<td>[01:02:55]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R: Um-hum, um-hum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P13: Oh, no problem. And, uh…</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[01:03:08]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R: So, always keep asking whether the support that [you know] that -- if it's actually helpful. P13: That you're delivering is actually helpful, [right] exactly - [right] is helpful. Uh, let me think about this.</td>
<td>That what you're delivering, Is actually helpful</td>
<td></td>
</tr>
<tr>
<td>[01:03:19]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
R: Yeah, take some time.

[participant thinking 01:03:20 - 01:03:27]

P13: And, yeah, I just think it's so easy to, uh, to alienate a person, that that's something to be very conscientious about. Whatever you ask or say to try not to alienate them because that -- then they probably won't trust you as much.

[01:03:49]

R: Okay, yeah. How do you -- what do you, like, how does that…

P13: What is an example?

[01:03:54]

R: So, I can understand that better.

P13: Well, I just -- I just think, like, it's just so easy to alienate someone, like, whether you -- whether you just show the inklings of that you're inpatient with them; that you can't understand. So, I just think, you know, always have a smile on your face. You know, always act like you're happy to see them, even if they're [yeah] fucking annoying you. Why, I'm just being honest.

[01:04:17]

R: Yeah, yeah, yeah.

P13: Because how you going to help them if they -- they think that, you know, that you think [yeah] that they're -- they're bothersome.

[01:04:25]

R: They're being bothersome, yeah,
being a burden or annoying.

P13: Annoying -- yeah, a burden or annoying or, like, hopeless. [yeah] Just act like -- act like you think -- I don't know, that it -- that it's -- that everything's going to be okay and that, like, I don't know. I don't know. I don't want -- I want to say that, like, I don't know. Just try to encourage them not to -- to think that every, you know, every mistake that they make is an opportunity to grow. You know, like, I think that feeling of embarrassed is okay or, you know, [yeah] and that, like, hopefully, make them believe that -- that it isn't hard -- isn't as hard as you think, even though - - even though it is, of course, it is. That it isn't as hard as they think, because, I think, yeah. I think a lot of -- a lot of, like, people get discouraged because it's so difficult and, you know, or even getting started on the work on yourself is the hardest so a thing, like, I don't know, conveying that feeling that, you know, everything's okay. And that it is, you know, this is tangible [um-hum] because, I think, a lot of people they get so discouraged because they think they -- they've made no progress or they're going to make no progress so that's what I think. [yeah] That they've got the light -- like, if you can -- if you can give them a vision of the light coming out of the tunnel then it's, like, it makes it just so that much more tangible that, like, look you've done this. That's, like, you're -- you know. [um-hum, um-hum] That's what I think.
And I think -- I think that's basically whatever it is -- it was okay to be sad, it's okay to be angry, it's going to be sad because -- because all these things are going to change. And, basically, yeah, I think that -- that's the most important thing that it's okay. Whatever you're feeling is okay. It's okay, like -- like, that's -- that's why I'm trying to support the information about the alienating thing. The alienating is the worst thing for someone going through, but I want to focus on the positive.

| To be sad, to be angry, to cry, or be confused Is okay |
| All these things are going to change. That's the most important thing, |