Gajwani, R., Larkin, M. and Jackson, C. (2018) “What is the point of life?”: An interpretative phenomenological analysis of suicide in young men with first-episode psychosis. Early Intervention in Psychiatry, 12(6), pp. 1120-127.

There may be differences between this version and the published version. You are advised to consult the publisher’s version if you wish to cite from it.

This is the peer reviewed version of the following article Gajwani, R., Larkin, M. and Jackson, C. (2018) “What is the point of life?”: An interpretative phenomenological analysis of suicide in young men with first-episode psychosis. Early Intervention in Psychiatry, 12(6), pp. 1120-127, which has been published in final form at http://dx.doi.org/10.1111/eip.12425. This article may be used for non-commercial purposes in accordance with Wiley Terms and Conditions for Self-Archiving.

http://eprints.gla.ac.uk/131795/

Deposited on: 23 November 2016

Enlighten – Research publications by members of the University of Glasgow
http://eprints.gla.ac.uk

“What is the point of life?”: An interpretative phenomenological analysis of suicide in young men with first-episode psychosis

Ruchika Gajwani[1]*, Michael Larkin[2], Chris Jackson[3]

[1]Institute of Health and Wellbeing, University of Glasgow, Glasgow, UK

[2]School of Psychology, University of Birmingham, Birmingham, UK

[3]Early Intervention Psychosis, Forward Thinking Birmingham, Birmingham, UK

* Correspondence should be addressed to Dr Ruchika Gajwani, Institute of Health and Wellbeing, University of Glasgow, Caledonia House, Yorkhill Hospital, Glasgow G3 8SJ, UK. (email: Ruchika.Gajwani@glasgow.ac.uk)

Abstract

Aim: Life time risk of suicide in first-episode psychosis far exceeds the general population, with the risk of suicide persisting long after first presentation. There is strong evidence to suggest that women more frequently attempt suicide, while men are at a greater risk of completing suicide. First-hand experiential evidence is needed in order to better understand men's motives for, and struggles with, suicidality in early psychosis.

Methods: Semi-structured interviews were conducted with seven participants. The interviews explored each respondent's account of their suicide attempt within the broader context of their life, in relation to their past, present and future. In line with the exploratory, inductive nature of the study, an Interpretative Phenomenological Analysis (IPA) was used to explore the meaning of suicide attempts in these accounts.

Results: Three super-ordinate themes emerged: *Self-as-vulnerable (intra- and inter-personal relationships)*, *appraisal of cumulative life events as unbearable.* and *meaning of recovery marked by shared sense of hope and imagery for the future*.

Conclusions: Young men in the early stages of their treatment are seeking to find meaning for frightening, intrusive experiences with origins which often precede psychosis. These experiences permeate personal identity, relationships and recovery. Suicide was perceived as an escape from this conundrum, and was pursued angrily and impulsively. By contrast, the attainment of hope was marked by sharing one's burden and finding a sense of belonging. Specialised assertive outreach programmes may be beneficial in improving the social inclusion of young men who may be particularly marginalised.

Keywords: Suicide, Gender, Young Men, Interpretative phenomenological analysis (IPA), First-episode psychosis

INTRODUCTION

Young men experiencing a first episode of psychosis are exposed to an inflated risk of death by suicide. On the basis of previous research and clinical experience, there are reasons to believe that the sources of this risk are likely to be linked to a number of inter-related factors, which include predisposing or causal contributors to the psychosis itself (such as prior trauma), the effects of the psychotic episode, and gendered appraisals of the meaning of the episode. In this qualitative study, we aim to learn more about young men's experience of suicidality in early psychosis, through in-depth interviews with suicide survivors.

Suicidality is a complex phenomenon, which can usefully be split into ideation, actuation and completion. Suicidal ideation is defined as thoughts about suicide with the wish to take one's own life; a suicide attempt is defined as deliberate self-injurious behaviour with the intention of ending one's own life [1]. The proportion of people with first-episode psychosis who report suicide attempts prior to treatment is considerably greater than the rate of reported suicide attempts at follow up [2]. Overall, the rate of suicidality in first-episode psychosis far exceeds the general population [3], with the risk of suicide persisting in the long term after first presentation [4, 5]. Lifetime suicide prevalence in first-episode psychosis has been estimated at over 5%, with a substantially increased risk earlier in the course of psychosis [6]. Evidence from a recent national survey of people with psychosis found that nearly one half (49.5%) reported attempting suicide in their lifetime, and a greater percentage reported life time prevalence of suicidal ideation[7].

Prediction of suicide risk in psychosis is complex, because knowledge is limited about the interaction between symptoms, and the extent to which comorbidity contributes to suicide[8, 9]. Systematic reviews and meta-analysis for suicide in schizophrenia [6, 10] and in first-episode psychosis[2] have implicated multiple demographic and clinical risk factors in different stages of emerging psychosis[11]. The multifactorial relationship between risk factors for suicide highlights the complexity of the phenomenon[12] and at the same time brings to the

forefront the limitations of *nomothetic* approaches[13], which move away from a contextual discussion of suicide[14].

Studies of gender differences in the presentation of first-episode psychosis have suggested differences in symptomology, with greater social anhedonia and poor social functioning amongst men[15] exacerbating substance misuse and undermining general functioning [16]. A young man's gender role may be closely associated with their occupational status and prospects, the loss of which has also been linked to suicide[17]. In a qualitative investigation with young men following their first-episode, Hirschfeld and colleagues[18] found that experiences of psychosis threatened identity and masculinity, due to missed opportunities in the context of age-related goals. Gender role stereotypes may promote the independence of young men and may unhelpfully prevent access to supportive social networks in an adjusted recovery process. Qualitative studies with a gendered focus upon first-episode psychosis may provide insights beyond what we already know about risk factors. The increased risk of completed suicide for young men with psychosis [3, 19] is poorly understood at an experiential level. It is important to conduct phenomenological studies in order to better understand the experiences from which suicidal feelings and behaviours emerge.

The aims of our study were two-fold: Firstly, to examine the personal meaning of their own suicide attempts for young men with a diagnosis of first-episode psychosis. Secondly, to explore young men's experience of emerging psychosis and it's relation to the suicide attempt, within the context of their life script. Interpretative Phenomenological Analysis (IPA) [20] was chosen as the appropriate method of qualitative analysis, because it directs the analyst to produce an in-depth account of experiential phenomena.

METHOD

Approach

In line with the exploratory, inductive nature of the study, an IPA [20, 21] approach was adopted. IPA is idiographic[22], in that it hopes to capture *particular* respondents' relationship to a shared experience, and it is phenomenological and interpretative, because it requires the researcher to explore and make sense of patterns in the participants' *meaning-making* about this experience.

Ethical approval was sought and granted from a Local Research Ethics Committee. Written informed consent was obtained from all the young men prior to study participation.

Sampling

IPA adopts a purposive approach to sampling and the sample-size was guided by its recommendations [20]. In line with this, our inclusion criteria (see Table 1) aimed to recruit a small number of participants with a shared relationship to both suicidality and psychosis. Participants were recruited from an Early Intervention Service (EIS) for psychosis in the UK, meeting ICD-10 criteria for Schizophrenia or related disorder (F20, 22, 23) in the absence of a primary diagnosis of organic disorders. We followed guidelines provided by Taylor et al.[23] for the ethical conduct of research in the area of suicide in schizophrenia, throughout the process of participant recruitment and data collection.

Participants

Our sample consisted of seven participants, all young men between the ages of 18 to 35, with a mean age of 22.85 (SD = 3.48). Three participants were unemployed and four were registered to resume their education. Two participants were of British Asian/Asian Pakistani ethnicity, one British African Caribbean and four White British. All had made a suicide attempt within an average of two years before the date of interview. One participant had

made a deliberate suicide attempt once prior to the experience of psychosis. All the young men had previously experienced severe suicidal ideation. Four participants described more than one attempt at ending their life.

TABLE 1 HERE

Semi-structured interview

A semi-structured interview schedule was prepared in consultation with the clinical and academic colleagues working in the area of Early Intervention Service for psychosis. The interview schedule (available on request) used open-ended questions that were exploratory in nature, as is typical in IPA [20]. The questions were designed to provide the participant the opportunity to describe and reflect on their experiences in the larger context of their life. For example, "What are your current thoughts and feelings about your life?" explored the participants' perceptions of their current life in light of their previous suicide attempt. Interviews took place in an environment familiar to the person, in an attempt to ensure the least amount of distress in discussing their experiences. The interviews lasted between 45 to 60 minutes each. They were audio recorded and transcribed in full.

Data analysis

The general process of analysis in IPA has been described extensively[20]. The process is broadly inductive, and develops iteratively and collaboratively through a series of stages, as summarised in Table 2, in order to identify patterns of meaning (themes) in the data. These patterns are first identified in each individual case, and then across the dataset as a whole.

TABLE 2 HERE

RESULTS

Three major super-ordinate themes emerged from the in-depth qualitative analysis of the interview data, namely: Self-as-vulnerable *(intra- and inter-personal relationships)*; *appraisal*

of cumulative life events as unbearable; and *meaning of recovery marked by shared sense of hope and imagery for the future* (see Table 3). The super-ordinate themes were endorsed by all participants, with varying degree of convergence and divergence of the sub-ordinate themes within their individual narratives. The description of suicide attempt(s), and the experiential claims associated with these were multifaceted and unique to the life script of each participant.

TABLE 3 HERE

Self-as-vulnerable (intra- and inter-personal relationships)

Lost self-identity

For the young men in this study, rapid changes in subjective experiences and the loss of self-identity emerged as a recurring theme, linked to their suicide attempts:

> *This is real you know, this is definite and finite and it's this evil thing within you, that's gonna make you do something terrible… you're completely losing your mind and who you are and what sort of person you use to be - the alternative there is just to (snaps his fingers) shut it off basically…You can end it if you chose to.* (Adam)

The overwhelming experience of self-in-crisis ("he fed on that" – the personified voice), and feeling "powerless" contributed directly to suicide attempts, as illustrated by Peter:

> *I didn't have a very good image of myself…I didn't think much of myself. At all. And so, he fed on that. Every time I hear him, he's like going on about how worthless I am, how I'm pointless, how I'm pathetic and it just doesn't, doesn't feel good.* (Peter)

Fathers as critical, distant or absent

Within the broader theme of strained interpersonal relationships, participants' collectively described fathers who were distant, absent or both. The narratives reflected paternal subordination, with elements of 'turbulent' interaction, or a loss of paternal care in teenage years:

> *The loss [of] my father (age thirteen) … I think not having a role model around the house, it affected me quite badly… school grades started going down quite badly and I started cannabis. I don't think my dad would have let me consume, so.* (Mark)

As we can see, in Mark's account of his bereavement, above, there was a sense of what a father *might* have provided. This *could* be read as the 'if only' component of an 'adverse early experiences' narrative, but it is worth noting that in Mark's account there is a keen sense of what may have been *lost:* a model of masculinity to aspire to; a degree of authority; someone to turn to in difficult moments.

The view of fathers was not always so positive. In some cases, the content of malevolent voices mirrored volatile paternal relationship; in others it represented feelings of a lack of care, intensifying a personal sense of vulnerability as illustrated:

> *My dad use to like bully me, was always very critical of me … the voices obviously took my own experiences of a child and drew on them, and that's why he* [voice] *would go on about my dad so much.* (Peter)

As these extracts demonstrate, the participants reflected on the lack of a strong, positive relationship with their fathers; in some cases this was described as being unsupportive or critical.

Appraisal of cumulative life events as unbearable

Unresolved early adverse experiences

Although participants reflected on a largely “happy childhood”, all narratives described serious adverse childhood experiences impacting their mental health, experienced as intrusive flashbacks. There is a sense of a serious negative, global impact on their lives, which led up to the suicide attempts:

> *About two years ago these flashbacks come like every week and because of these flashbacks I tried to commit suicide three times … I believe they have changed me in every way. (Imran)*

The indelible impact of adverse childhood experiences on their “illness” experience emerged in the narratives, as illustrated:

> *You can see little bits of it throughout your life basically when you look at your mental illness, you can see parts of your life which have been leading up to it, contributing towards it, like bullying … teasing basically, that can get you very angry, almost horribly angry.* (Adam)

As in Adam’s case, there was a physical expression of past victimisation, which resurfaces as a “real shock”, transforming into “unbearable anger”.

Social isolation

Isolation, loneliness and withdrawal from society were reflected on as the nadir of distress. For some, social isolation meant active social avoidance, whereas for others it was feelings of exclusion:

> *I don’t know how to get out and find a new group of friends really that don’t smoke. I think the depression was first and then I started using cannabis to sort of medicate myself but it ended up making things worse.* (Mark)

As illustrated in Chris’s account, young men in this study often described themselves as “outcasts”, who were attempting to “engineer a life” to “reduce as much suffering as possible”.

> *I was spending a lot of time alone, smoking a lot of cannabis. I generally felt quite cut off from the rest of the world … Umm, because of my feelings of loneliness, I- I felt that life- don't know, life was just very difficult …and so I thought of various ways of committing suicide. (Chris)*

Although Chris's account of contemplating suicide seems 'matter of fact', his narrative of 'social isolation' encapsulates an existential sense of loneliness; not knowing how to rebuild "lost relationships" whilst making sense of very difficult experiences.

Meaning of recovery marked by shared sense of hope and imagery for the future

Within the context of their past suicide attempts were reflections on the ongoing recovery process.

Hope vs. Hopelessness

Amongst those who spoke hopefully of the future, there was a sense of opportunities to explore, whilst "catching up" on lost time, to "master" what *might* appear to be uncomplicated tasks:

> *I guess it's still early days in some ways … so many different stages of recovery, going from actively getting up in the morning which takes ages to master you know, all the way through to interactions with other people, thoughts and ideas about the world, all these different stages of recovery, so I think I'm doing alright. (Peter)*

There were others, who felt less hopeful, with the dilemma of speaking openly about suicide which may result in "hospitalisation", whilst the questions of *what else* are left unaddressed:

> *What is the point of life. What is the point of life? What are you supposed to do every day? Just work, eat, drink, watch tv, that's what life is? Do you know what I mean? All I remember was that I was feeling low. I took some paracetamol. I wanted to die.* (Amir)

Amir's account reflects a state of *nothingness*, a fragile position which young men in early psychosis may contend with when they feel most vulnerable.

Shared meaning and burden

Within descriptions of shared experiences, there were narrative accounts of rebuilding relationships with family and friends, strengthening feelings of inclusion and being cared for. For example:

> *It's been helpful to relate to someone really. Know that others have been through the same stuff that I went through but dealt with it better. Had different ways of coping … it's made me realise that life is more precious really.* (Mark)

Mutual support through *shared experience* was perceived as helpful in the recovery process. Good relations with their current mental health team, including access to talking therapy and peer support groups was seen as important to recovery. Ambiguity about the future was linked to themes of feeling "cast out from the world", and a "troubled relationship" with oneself, as illustrated by Chris:

> *I'm trying to ride things through in my own mind, gain perspectives on things but, you know sometimes just talking, thinking about things can go round and round and not really find any clear answers. Sometimes as I say I can feel pretty- pretty lonely.*(Chris)

DISCUSSION

With the aim of understanding the nature and phenomenology of suicidality amongst young men with a first-episode psychosis, this study explored the intersubjective meaning of suicide and illness perceptions within the context of their life script. The analysis found three related themes. Central to the theme of *Self-as-vulnerable (intra- and inter-personal relationships)* was a growing dissatisfaction with relationships. Within the narrative of lost-self-identity were feelings of pointlessness and deep apathy. Subjective disturbances of the self have been shown to specifically predict the onset of psychosis[24, 25] and to permeate different facets of

anomalous 'self-experience' specific to schizophrenia[26]. In this study, young men indicated disturbances in *intra-personal* relations (pre and post emergence of psychosis); this concept needs further investigation in early psychosis because *intra*personal positive future thinking (i.e. positive prospective thoughts related to the individual and no one else, for example, 'getting better', 'recovering') has been shown to be highly predictive of future suicide attempts[27]. Initially this appears inconsistent with the view that hopelessness is significantly associated with a lack of fluency for positive future events[28] but we might speculate that the narrow, internal focus of this form of hopefulness has a negative effect when it is incongruent with experience.

Self-as-vulnerable also emerged in the participants' narratives on strained *inter-personal* relations, particularly regarding paternal subordination or absence. This may resonate with a perception of vulnerability in relation to the emerging psychosis. Drawing on models of attachment and social rank, Birchwood and colleagues[29] have shown that internalised representations of subordination and inferiority have a negative influence on the power of the 'voice' and depression in schizophrenia.

The co-occurence of strained interpersonal relations and participants' *appraisal of cumulative life events as unbearable,* may reflect the role of unresolved early adverse experiences on stress sensitivity in psychosis[30]. Evidence that childhood adversity increases the risk of psychosis has been strongly established[31]; however the mechanisms linking childhood adversity and suicidality in psychosis remain underdeveloped. In our study, within the individual context of psychosis, participants described moments of intense anger emerging from past victimisation and bullying, which rapidly changed to deliberation of, and then attempts at, suicide. This may be closely connected to the concepts of 'lack of inherent-worth' and 'mistrust' which together contribute to processes leading to suicidal attempts[32]. Prior experiences of anger, poor anger-regulation, and increased impulsivity, have been shown to be significantly associated with compliance to harmful command hallucinations[33].

Cumulative stressful life events prior to, and as a consequence of, psychosis led to experiences of social withdrawal, isolation and exclusion. These were perceived by the participants as worsening their distress and in some cases, as a trigger for their suicide attempts. Such premorbid social withdrawal has been shown to be a predictor for transition to psychosis amongst 'high-risk' young adults[34] and of relapse following first-episode psychosis [35].

The theme of *meaning of recovery marked by shared sense of hope and imagery for the future* described the recovery process. Four participants appraised their recovery positively, with hopes, goals for the future and a renewed sense of belonging, while others' spoke of more ambiguity, with a continued sense of hopelessness and lack of vision for the future. These findings are consistent with the interpersonal theory of suicide [36] which proposes two constructs central to suicidal desire – 'thwarted belongingness' and 'sense of burden' (self and others). Pathways to depression in psychosis are varied [37]. Careful clinical consideration is needed to support recovery in early psychosis [38]. Johnson and colleagues [39] found that positive self-appraisals moderated the association between hopelessness and suicidal ideation amongst individuals with psychosis. Our findings are consistent with a socially orientated model of recovery and growth within mental health[40], and reveal an increased sense of hope in the narratives of those who described a gradual improvement in self-worth, while reflecting on reclaiming their identity through a growing connectedness to young people's services and others.

Implications

The findings of this study suggest that young men, particularly in the early stage of their treatment, may find meanings for their frightening experiences which permeate personal identity, isolate them from relationships and threaten their sense of belonging. The research crucially identifies young men who may not follow a traditional model of recovery [41], and are hesitant to seek-help or express their distress.

Further exploration of the emerging concepts of 'shared burden' and 'sense of belonging'[36] amongst young men may be crucial for supporting recovery from suicide in the emerging psychosis. Gender research within first-episode psychosis is gradually building an evidence base, as it is particularly useful in the national discourse on suicide.

Strengths and limitations

Conclusions drawn from the findings of this study must be interpreted along with its methodological considerations. The study was unable to draw out any generalizable temporal models of suicide in this sample group, as the study endeavoured to examine the phenomenology of suicide attempts by young men in the context of first-episode of psychosis. Whilst IPA is avowedly idiographic, it privileges depth over breadth, and hence utilises smaller samples valuable for in-depth exploration of the data. The emerging themes aligned with the recurring themes of building identity, meaning-making and transforming relationships described in qualitative research on first-episode psychosis [42]. The recent resurgence of gender studies in the early stages of psychosis [15, 16, 43] are also encouraging the consideration of significant gender differences in early intervention treatment programmes, which may be particularly beneficial for suicide prevention.

REFERENCES

1. Lewinsohn PM, Rohde P, Seeley JR. Adolescent suicidal ideation and attempts: Prevalence, risk factors, and clinical implications. Clinical Psychology: Science and Practice. 1996; 3: 25-46.
2. Challis S, Nielssen O, Harris A, Large M. Systematic meta-analysis of the risk factors for deliberate self-harm before and after treatment for first-episode psychosis. Acta Psychiatrica Scandinavica. 2013; 127: 442-54.
3. Nordentoft M, Jeppesen P, Abel M, et al. OPUS study: suicidal behaviour, suicidal ideation and hopelessness among patients with first-episode psychosis. The British Journal of Psychiatry. 2002; 181: s98-s106.
4. Dutta R, Murray RM, Hotopf M, Allardyce J, Jones PB, Boydell J. Reassessing the long-term risk of suicide after a first episode of psychosis. Archives of general psychiatry. 2010; 67: 1230-7.

5. Robinson J, Harris M, Harrigan S, et al. Suicide attempt in first-episode psychosis: a 7.4 year follow-up study. Schizophrenia research. 2010; 116: 1-8.
6. Palmer BA, Pankratz VS, Bostwick JM. The lifetime risk of suicide in schizophrenia: a reexamination. Archives of general psychiatry. 2005; 62: 247-53.
7. Morgan VA, Waterreus A, Jablensky A, et al. People living with psychotic illness in 2010: The second Australian national survey of psychosis. Australian and New Zealand Journal of Psychiatry. 2012; 46: 735-52.
8. Cavanagh JT, Carson AJ, Sharpe M, Lawrie SM. Psychological autopsy studies of suicide: a systematic review. Psychological medicine. 2003; 33: 395-405.
9. Nock MK, Hwang I, Sampson N, et al. Cross-national analysis of the associations among mental disorders and suicidal behavior: findings from the WHO World Mental Health Surveys. PLoS Medicine. 2009; 6: e1000123.
10. Hor K, Taylor M. Review: Suicide and schizophrenia: a systematic review of rates and risk factors. Journal of psychopharmacology. 2010; 24: 81-90.
11. Pompili M, Serafini G, Innamorati M, et al. Suicide risk in first episode psychosis: a selective review of the current literature. Schizophrenia Research. 2011; 129: 1-11.
12. O'Connor RC, Nock MK. The psychology of suicidal behaviour. The Lancet Psychiatry. 2014; 1: 73-85.
13. Lester D. Qualitative research in suicidology: thoughts on Hjelmeland and Knizek's" why we need qualitative research in suicidology". Suicidology Online. 2010; 1: 76-8.
14. Hjelmeland H, Knizek BL. Why we need qualitative research in suicidology. Suicide and Life-Threatening Behavior. 2010; 40: 74-80.
15. Thorup A, Albert N, Bertelsen M, et al. Gender differences in first-episode psychosis at 5-year follow-up–two different courses of disease? Results from the OPUS study at 5-year follow-up. European Psychiatry. 2014; 29: 44-51.
16. Cotton S, Lambert M, Schimmelmann B, et al. Gender differences in premorbid, entry, treatment, and outcome characteristics in a treated epidemiological sample of 661 patients with first episode psychosis. Schizophrenia Research. 2009; 114: 17-24.
17. Qin P, Mortensen PB, Agerbo E, Westergard-Nielson NIELS, Eriksson TOR. Gender differences in risk factors for suicide in Denmark. The British Journal of Psychiatry. 2000; 177: 546-50.
18. Hirschfeld R, Smith J, Trower P, Griffin C. What do psychotic experiences mean for young men? A qualitative investigation. Psychology and Psychotherapy: Theory, Research and Practice. 2005; 78: 249-70.
19. De Hert M, McKenzie K, Peuskens J. Risk factors for suicide in young people suffering from schizophrenia: a long-term follow-up study. Schizophrenia research. 2001; 47: 127-34.
20. Smith JA, Flowers P, Larkin M. Interpretative phenomenological analysis: Theory, method and research. Sage; 2009.

21. Larkin M, Thompson AR. Interpretative phenomenological analysis in mental health and psychotherapy research. Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners. 2012: 99-116.
22. Smith JA. Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. Qualitative research in psychology. 2004; 1: 39-54.
23. Taylor PJ, Awenat Y, Gooding P, et al. The subjective experience of participation in schizophrenia research: A practical and ethical issue. The Journal of nervous and mental disease. 2010; 198: 343-8.
24. Schultze-Lutter F, Ruhrmann S, Klosterkötter J. Can schizophrenia be predicted phenomenologically. Evolving psychosis, Different Stages, Different Treatments Routledge. 2006: 104-23.
25. Nelson B, Thompson A, Yung AR. Basic self-disturbance predicts psychosis onset in the ultra high risk for psychosis "prodromal" population. Schizophrenia bulletin. 2012; 38: 1277-87.
26. Parnas J, Handest P. Phenomenology of anomalous self-experience in early schizophrenia. Comprehensive psychiatry. 2003; 44: 121-34.
27. O'Connor RC, Smyth R, Williams JMG. Intrapersonal positive future thinking predicts repeat suicide attempts in hospital-treated suicide attempters. Journal of consulting and clinical psychology. 2015; 83: 169.
28. Williams JMG, Van der Does AJW, Barnhofer T, Crane C, Segal ZS. Cognitive Reactivity, Suicidal Ideation and Future Fluency: Preliminary Investigation of a Differential Activation Theory of Hopelessness/Suicidality. Cognitive Therapy and Research. 2008; 32: 83-104.
29. Birchwood M, Gilbert P, Gilbert J, et al. Interpersonal and role-related schema influence the relationship with the dominant 'voice'in schizophrenia: a comparison of three models. Psychological medicine. 2004; 34: 1571-80.
30. Lardinois M, Lataster T, Mengelers R, Van Os J, Myin-Germeys I. Childhood trauma and increased stress sensitivity in psychosis. Acta Psychiatrica Scandinavica. 2011; 123: 28-35.
31. Varese F, Smeets F, Drukker M, et al. Childhood adversities increase the risk of psychosis: a meta-analysis of patient-control, prospective-and cross-sectional cohort studies. Schizophrenia bulletin. 2012; 38: 661-71.
32. Benson O, Gibson S, Boden ZV, Owen G. Exhausted without trust and inherent worth: A model of the suicide process based on experiential accounts. Social Science & Medicine. 2016; 163: 126-34.
33. Bucci S, Birchwood M, Twist L, Tarrier N, Emsley R, Haddock G. Predicting compliance with command hallucinations: Anger, impulsivity and appraisals of voices' power and intent. Schizophrenia research. 2013; 147: 163-8.

34. Miller P, Byrne M, Hodges A, Lawrie S, Owens D, Johnstone E. Schizotypal components in people at high risk of developing schizophrenia: early findings from the Edinburgh High-Risk Study. The British Journal of Psychiatry. 2002; 180: 179-84.
35. Robinson D, Woerner MG, Alvir JMJ, et al. Predictors of relapse following response from a first episode of schizophrenia or schizoaffective disorder. Archives of general psychiatry. 1999; 56: 241-7.
36. Van Orden KA, Witte TK, Cukrowicz KC, Braithwaite SR, Selby EA, Joiner Jr TE. The interpersonal theory of suicide. Psychological review. 2010; 117: 575.
37. Birchwood M, Iqbal Z, Upthegrove R. Psychological pathways to depression in schizophrenia. European archives of psychiatry and clinical neuroscience. 2005; 255: 202-12.
38. Hodgekins J, Fowler D. CBT and recovery from psychosis in the ISREP trial: mediating effects of hope and positive beliefs on activity. Psychiatric Services. 2010; 61: 321-4.
39. Johnson J, Gooding PA, Wood AM, Taylor PJ, Pratt D, Tarrier N. Resilience to suicidal ideation in psychosis: Positive self-appraisals buffer the impact of hopelessness. Behaviour research and therapy. 2010; 48: 883-9.
40. Tew J, Ramon S, Slade M, Bird V, Melton J, Le Boutillier C. Social factors and recovery from mental health difficulties: a review of the evidence. British journal of social work. 2011: bcr076.
41. Liberman RP, Kopelowicz A. Recovery from schizophrenia: a concept in search of research. Psychiatric Services. 2005; 56: 735–42.
42. Boydell KM, Stasiulis E, Volpe T, Gladstone B. A descriptive review of qualitative studies in first episode psychosis. Early intervention in psychiatry. 2010; 4: 7-24.
43. Køster A, Lajer M, Lindhardt A, Rosenbaum B. Gender differences in first episode psychosis. Social psychiatry and psychiatric epidemiology. 2008; 43: 940-6.

TABLE 1 ***Inclusion criteria***

i.	First episode psychosis
ii.	Gender: Men
iii.	Age: 18 to 35
iv.	Duration in Early intervention service: participants would have been in the care of early intervention service for a minimum of six months
v.	The participant does not have florid symptoms of psychosis and permission for recruitment and participation is granted from the participants RMO
vi.	Have made a suicide attempt in the last twenty four months that has led to medical intervention*
vii.	No current risk of self-harm or harm to others (unless otherwise specified in the research interview)

* Medical intervention was defined as hospital admission or acute psychiatric intervention following a suicide attempt

TABLE 2 *The process of data analysis in IPA*

Stages	Process	
Familiarisation and reflection	Reading each transcript, and then rereading to make notes on initial thoughts, observations, and reflections.	First author
Reflection and preparation	Theoretical assertions and personal values were reflected on with second and third authors, and an attempt was made to 'bracket' these out.	All authors
Experiential coding	Systematic line-by-line analysis of each transcript for conceptual, descriptive and linguistic coding, annotated on the right hand side of the page.	First author, in consultation with second.
Integrative and interpretative coding	Higher order coding was synthesised and emerging patterns summarised for every participant on the left hand side of the page.	First author, in consultation with second.
Organisation	A worksheet was developed for each participant with the documented codes, quotes and line numbers, clustered under their corresponding themes.	First author, in consultation with second.
Thematic development	Convergence and divergence of clusters within individual cases, as well as across the data set were organised under a super-ordinate theme.	First author, in consultation with second.
Thematic structure	A summary of clusters (i.e. superordinate themes) was developed, with underlying themes, relevant quotations and references within the text.	All authors

TABLE 3 *Super-ordinate and sub-ordinate themes identified*

Superordinate theme	Sub-ordinate theme	Quotes*
Self-as-vulnerable (intra- and inter-personal relationships)	Lost self-identity	*I just thought I was the one person in the world and that it wasn't happening to anyone else in the world. That made me feel low and something different, not human.* (Amir) *Medication isn't yourself either. It's more yourself than mental illness… Er, I was just walking and I just felt really strong. Just numb, comp-completely numb from medication. Just not myself at all. It was weird. I suppose I had been feeling better I think. I wanted something to change and I couldn't really work out what it was so, I just thought that (jumping from a building) would satisfy me at the time I suppose.* (Adam) *I felt out of place with everyone. Like at school, I felt I wasn't normal. Like everyone else was having their own normal little life and mine wasn't, normal. It was, it was weird.* (Peter) *I find it hard to trust people and I've kind of managed to engineer a life where, I'm kinda trying to reduce as much suffering as possible by reducing the amount that I have to speak to people because I find it very, very difficult sometimes to maintain cer-hap-normal happy social conduct with people.* (Chris)
	Fathers as distant or absent	*Family life has always been a little bit turbulent. My dad left the country when I was ten years old. He went to America to kind of start a new life, so it was just me and my mum really.* (Chris)

		I had a real big problem with eating and er, my dad use to like bully me about my eating, and take the piss out of me at the dinner table… dad was always very critical of me like, I wasn't very good at maths… And he'd shout at me, he'd shout at me, shout at me about not being able to do it. (Peter) *The reason why I went to the doctors in the first place was because me and my dad were arguing… he really was getting me down. The one time we were at my nan's and he had a fit on me and a full on fight with my dad. If it wasn't for my next door neighbour, we would have ended up fighting in the middle of the street, but yeah he switched on me and my nan was trying to get him off me.* (Alex) *I didn't see my dad much cause him and my mum divorced when I was ten years old and he died when I was thirteen… It shut me straight down. I was always happy and just don't know, I didn't think something like that could just change my life so quickly.* (Mark)
Appraisal of cumulative life events as unbearable	Unresolved early adverse experiences	*In prison, I got into a fight and I got cut and I remember feeling … paranoia, anxiety. But the real anxiety and the voices started when I got kidnapped… I felt better when I was in prison.* (Amir) *They came with the guns and they tried to attack our home… After one year my mother was okay but I'd still feel stressed. That past was scary. .. I believe my relationship, my thoughts, my trust, my concentration, everything has changed now from before the experience.*(Imran)

	It was just verbal mostly. I don't think I was ever hit or anything. It was just, it's like, teasing basically, that can get you very angry, almost horribly angry. I use to count to ten and they would go away, whereas when you're mentally ill, counting till ten doesn't really do anything. Not for me anyway. (Adam)
Social isolation	*A bit stressful cause a lot of my friends, I've been friends with since I was eleven years old and I've lost them just in the last year so … Just a bit isolated, and lonely really.(Mark)*
	I was going through a hard time evidently to even contemplate killing yourself, cutting yourself and all those things…it makes you feel like your crazy beyond belief, it makes you feel like you're mad and don't know what to do, it makes you feel isolated. (Alex)
	I'm quite a different person to the person I used to be. Umm, don't feel as confident, or as sociable… I feel like a bit of an outcast from the, from the rest of society. I just go through periods of feeling very, very low and lonely really. (Chris)
	Friends, I never liked their habits, smoking and stuff. Never liked my family. Never liked no-one…I tried to battle it out of myself before the medication and it was getting worser and worser. (Amir)
	I don't really interact with people. I don't want to meet them or if someone wants to be friends with me, I just stay away. Because most of the time I'm really depressed, I don't want to talk to anybody or go out (Imran)

Meaning of recovery marked by shared sense of hope and imagery for the future	Hope vs. Hopelessness	*I got a bit more hope, like I'm going to college again, next year. Try do the same course again. So, catch up. And looking for work at the moment, so, on the up really.* (Mark) *Sometimes I think there is no bright future for me. Whenever I want to do something, my past experience, the voices stop me…. Because when I made friends to go to University, be normal, these voices really stop me...Because when there is no way out, it's the conclusion how, what is the best way. So, my view is after death is, its much better.* (Amir) *I don't know what is the meaning of life, you know. I don't see the point. Do you? Sometimes I think that life could be this and life could be better. But I don't know how.* (Imran) *It is the young person's thing, I think. I know there are older people who commit suicide and stuff but it's like a phase, its best that if you want to help people, make them aware that it's a phase, cause there is an anger that young men get, just that never seems to want to go away, for you know years that can happen, being like this into their thirties and stuff. But if they know they can get help in many ways really. Different people. Then the world would get better basically.* (Adam) *I'm alive for a reason, I tried to end my life enough times, enough times and I've lost count of the amount of times so it's like I'm alive for a reason. Hopefully I think I'm on the way to recovery.* (Alex) *I don't really have too much hope* (Chris).

	Shared meaning and burden	*You can talk about it to them obviously cause they've all suffered at some point. You can go to the drop-in and see a doctor or you can have a doctor come and see you or you can just call up your care-worker … [if] you need to talk to someone you can, there is always someone there. It's just made my life easy.* (Adam) I*t's made me realise that life is more precious really. I've got a lot more people that care about me and I think its helped me, help others as well cause I've had couple of mates who have had similar experiences and I've been able to share my story with them. To help them, so. So, although its been quite a traumatic experience, its been quite helpful.* (Mark) *I couldn't do this with out her (keyworker) and the team, that's an honest opinion. If I didn't have her and I was by myself I would have given up long time ago and that's the honest truth.* (Alex) *It all seems like they want something else from what I want though which always puts me at loggerheads with my mum for instance…My mum was kind of campaigning for me to stay in hospital…I was given an ultimatum to either stop taking cannabis or to umm, be put back down on medication, forcefully… I don't believe in these, the power of prescription drugs to just heal, you know, mental, psychological trauma.(*Chris)

***** Participant names were replaced with pseudonyms in transcripts and the article to maintain anonymity