

# Self-Compassion and Self-Criticism in Recovery in Psychosis: An Interpretative Phenomenological Analysis Study

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**Objective:** To increase understanding of the internal processes of recovery in psychosis, with particular consideration given to self-compassion and self-criticism. **Method:** Qualitative data were collected by semistructured interviews, from 10 participants with psychosis, and analyzed using interpretative phenomenological analysis. **Results:** Five superordinate themes emerged: (a) “my mind can’t take the load”: the “curse” of psychosis; (b) the “trap” of self-criticism; (c) “coming to terms” with psychosis in my life to “move on”; (d) “on my own two feet”; and (e) “an opportunity” for growth. The themes included a reciprocal relationship between psychosis and self-criticism, processes of acceptance, empowerment, and posttraumatic growth. **Conclusions:** The internal process of self-to-self relating contributed to 2 maintenance cycles: self-criticism maintained distressing experiences of psychosis and compassionate self-acceptance resulted in empowered action and promoted recovery and growth. The dual process of acceptance and change in relationship to self was central to recovery. © 2015 Wiley Periodicals, Inc. *J. Clin. Psychol.* 71:1201–1217, 2015.

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## Overview

Psychosis is a distressing experience associated with considerable disability and health burden (World Health Organization, 2001). Thus, understanding the process of recovery is a key aim for research and clinical practice. Recovery from psychosis has been the focus of much research (e.g., Andreason, Oates, & Caputi, 2003; Kelly & Gamble, 2005), which in turn has informed service development (Bird, Leamy, Le Boutillier, Williams, & Slade, 2011). Recovery is a multifaceted concept that has been defined in terms of functional outcome, symptom amelioration, and distress reduction (Bonney & Stickley, 2008). These definitions imply a distinction between illness and wellness; however, this study is focused on the process of recovery and change in relationship to self rather than a predefined outcome. Reconstructing a sense of self has been identified as a key stage in models of recovery (Andreason, Oates, & Caputi, 2003) and after first episode psychosis (Romano, McCay, Goering, Boydell, & Zipursky, 2010).

Recent developments in theoretical formulations (Gumley, Braehler, Laithwaite, MacBeth, & Gilbert, 2010) indicate self-to-self relating may be a critical process in recovery, as relationship with self may promote or hinder recovery. Self-to-self relating refers to the way in which individuals relate to themselves and can be considered their intrapersonal relationship. However, the experience of this internal process of change, with a focus on the intrapersonal relationship, has yet to be explored using qualitative methods. Qualitative research uses personal accounts to enhance understanding of the phenomenological experience. This will yield new information about the experience of psychosis, its effect on the self-concept, and how this affects the

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recovery process. Therefore, this study aims to explore the internal process of recovery from the first-person perspective.

### *Self-Criticism*

The experience of psychosis can lead to experiences of both internal and external shame (Turner, Bernard, Birchwood, Jackson, & Jones, 2013). External shame is the sense that one is judged negatively in the minds of others; in contrast, internal shame relates to the negative evaluation of the self (Gilbert, 2009a). There is considerable evidence that psychosis carries severe social stigma (Hayward & Bright, 1997), which can result in both external and internal shame (Hasson-Ohayon et al., 2012), affecting self-esteem, hope, and quality of life (Mashiach-Eizenberg et al., 2013). Because of service users' experience with mental illness and/or public stigma, self-stigma can be understood as their internalized negative reactions to the prejudice and stereotypes of others (Corrigan & Watson, 2002).

Further to this, self-criticism is the characteristic self-talk associated with the experience of shame, the sense of being flawed or undesirable to others (Gilbert & Irons, 2005; Tantam, 1998) and may result in people struggling to feel safe, reassured, or content (Gilbert, 2009a). Thus, self-criticism is about the way one interacts with oneself (Hutton, Kelly, Lowens, Taylor, & Tai, 2013). Self-criticism and shame are transdiagnostic problems that "play a major role in many forms of psychological difficulty" (Gilbert & Irons, 2005, p. 263) including psychotic voice hearing (Gilbert et al., 2001) and persecutory delusions (Hutton et al., 2013).

High levels of shame and self-criticism are common features for many people in recovery from psychosis (Gumley et al., 2010) and are associated with postpsychotic depression (Iqbal, Birchwood, Chadwick, & Trower, 2000), postpsychotic social anxiety, (Birchwood et al., 2006) and postpsychotic trauma symptoms (for example, intrusive reexperiencing, avoidance, and hyperarousal that occur after an episode of psychosis; Turner et al., 2013). Thus, shame and self-criticism may contribute to the experience of psychosis as well as secondary difficulties that may delay or prevent functional and symptomatic recovery. This theoretical reflection indicates the need to explore experiences of self-criticism in recovery in psychosis.

### *Self-Compassion*

People with high levels of self-criticism can experience particular difficulty responding to setbacks, being kind to themselves, or experiencing self-compassion (Gilbert, 2009a; Kelly, Zuroff, & Shapira, 2009). Self-compassion refers to "the ability to hold one's feelings of suffering with a sense of warmth, connection, and concern" (Neff & McGehee, 2010, p. 226) and is beneficial in reducing psychological distress and increasing well-being (Gilbert, 2009b; Neff, Kirkpatrick, & Rude, 2007). Higher levels of self-compassion are reportedly associated with lower rates of positive symptoms of psychosis (Eicher, Davis, & Lysaker, 2013). Eicher and colleagues (2013) suggest that this finding can be understood referencing nonclinical findings that increased compassion is associated with increased well-being and lower levels of distress (Neff, 2003). The Gumley et al. (2010) framework also suggests that compassion could be a way to soothe oneself when the threat system is activated by self-criticism. Eicher et al. (2013) state that self-compassion "could be an important factor as individuals attempt to make sense of their mental illness" (p. 4).

Gumley et al. (2010) apply the principles of compassion-focused therapy (CFT; Gilbert, 2010) in their model of recovery after psychosis. They propose that compassionate responding may alleviate perceived threat and enhance a sense of safety, thus promoting recovery after psychosis. Early phase research evidence, including a feasibility randomized controlled trial (Braehler et al., 2013), a forensic inpatient group intervention (Laithwaite et al., 2009), and a case series (Mayhew & Gilbert, 2008), indicates support for the use of CFT in psychosis. However, these interventions have focused on emotional recovery (Braehler et al., 2013), and improving depression, self-esteem, developing self-compassion, and reducing external shame (Laithwaite et al., 2009), and not on reducing distressing psychotic symptoms.

Theoretical models and clinical case examples support the potential importance of self-compassion and self-criticism in recovery in psychosis. However, specific exploration of the internal processes of recovery, including self-to-self relating, from the first-person perspective is yet to be achieved. Interpretative phenomenological analysis (IPA), with its focus on the subjective experience and the sense-making process, would enable an investigation of the nature and experience of internal factors, including self-to-self relating, and how they may be understood from the first-person perspective.

The aim of this study is to build a greater understanding of the internal processes of recovery in psychosis, including how one relates to oneself and how this internal relationship may influence recovery. This study uses IPA to explore the meaning of recovery from the first-person perspective, with particular consideration given to self-compassion and self-criticism.

## Method

### *Design*

This study was an exploratory, qualitative analysis using a semistructured interview to explore self-to-self relating in recovery in psychosis.

### *Participants*

*Recruitment.* Purposive homogenous sampling was used to identify participants for whom the research question was significant (Smith, Flowers, & Larkin, 2009). Mental health professionals from a community mental health team in the United Kingdom identified potential participants. Participants were eligible to be interviewed if they had experienced positive symptoms (e.g., hallucinations, delusions, disorganized speech, or behavior) of psychosis, which started at least 3 years before participation; were aged between 18 and 65 years; were able to give informed consent; and speak English.

Exclusion criteria were based on concerns regarding capacity to consent (e.g., diagnosis of moderate or severe learning disability) and risk of distress caused by participation (e.g., due to acute psychotic symptoms that significantly affect functioning or current high risk of harm to self or others). Therefore, clinicians at the local mental health service completed assessment of acute symptoms and risk. Of the 19 people approached, four declined, five did not meet inclusion criteria, and 10 agreed to participate (seven men and three women). Written informed consent, including consent to the use of anonymized quotes, was obtained.

*Participant characteristics.* Participant characteristics are included in Table 1. Participants were aged between 25 and 52 years (mean = 35.8 years, standard deviation (SD) = 9.5 years). The age of onset of psychosis ranged from 16 to 43 years (mean = 22.8 years, *SD* = 8.0 years). Working diagnoses (noted from existing medical records) included paranoid schizophrenia, schizotypal disorder, and schizophrenia with secondary depression. One participant did not have a working diagnosis. Thus, the homogeneity of the sample is linked to experiences of distress and desire for recovery rather than a specific diagnostic label.

### *Procedure*

*Ethics.* This study was reviewed and approved by a National Health Service ethics review committee.

*Interview.* A semistructured interview schedule was developed based on existing literature, including IPA research exploring experiences of psychosis (e.g., Knight, Wykes, & Hayward, 2003; Perry, Taylor, & Shaw, 2007), established psychometric measures exploring the concepts of self-compassion (Neff, 2003) and shame (Goss, Gilbert, & Allan, 1994), and guidance on the principles of IPA methodology (Smith et al., 2009). Local service users and nonprofessional carers were consulted regarding the development of the interview schedule and 12 individuals provided detailed feedback on drafts.

**Table 1**  
*Participant Characteristics*

Pseudonym	Gender	Age (years)	Ethnicity	Marital status	Accommodation	Occupation	Working diagnosis	Age at onset (years)
Adam	Male	29	White-British	Divorced	Living with parents	Unemployed	Paranoid schizophrenia with secondary depression	18
Esther	Female	25	Mixed-Caribbean	Single	Living alone	Unemployed	Paranoid schizophrenia	16
Dean	Male	27	English	Single	Living with mother and sister	Unemployed	None	16
Joe	Male	52	Pakistani	Separated	Living alone	Voluntary work	Schizophrenia and post-schizophrenic depression	22
Starr	Male	42	Kashmiri	Married	Living with wife and children	Voluntary work	Bipolar/Schizophrenia/ Psychotic depression	19
James	Male	28	White-American	Single	Supported housing	Voluntary work	Paranoid schizophrenia	24
Connor	Male	29	White-British	Single	Living with mother	Unemployed	Psychosis and depression	25
Lisa	Female	47	Mixed-British	Single	Supported housing	Unemployed	Paranoid schizophrenia	43
Maria	Female	37	Pakistani-British	Single	Living with mother and sister	Unemployed	Schizophrenia	27
Bubbles	Male	42	White-British	Married	Living with wife	Unemployed	Schizotypal disorder	18

The interview included open-ended questions covering the following broad topics: “How do you view recovery?”; “Has psychosis brought any knowledge or experiences in to your life you might not have had?”; “Were there any things that made it harder to recover?”; and “When things aren’t going well in your life, how do you manage that?” The schedule was used flexibly, additional prompts were used as necessary, and participants’ own vocabulary was used whenever possible. The interviews ranged in length between 45 and 65 minutes and were conducted, audio-recorded, and transcribed verbatim by the principle researcher (FW, a clinical psychologist in training). Participants were invited to select a pseudonym and identifying information was removed to ensure anonymity.

Two pilot interviews were conducted. The pilot interviews identified the importance of prompts in extending and clarifying the conversation, for example, asking what types of things they do for themselves when they are on their own helped to expand the conversation from practical support given by others to internal resources and support given to self by self, i.e., self-to-self-relating. There were no changes to the major questions, only changes to the order or prompts based on their ability to open topics; therefore, the pilot data were included in the final analysis.

### *Data Analysis*

IPA is an idiographic approach that aims to understand how an individual makes sense of and gives meaning to their experiences (Smith, 1996). The principle researcher (FW), who followed the IPA procedure recommended by Smith et al. (2009), conducted the analysis. After transcription, interviews were read and reread to increase familiarity. *Exploratory comments* including descriptive, linguistic, and conceptual aspects were noted. A process of identifying and labeling *emergent transcript themes*, which reflect both the participants’ comments and the interpretation of the analyst, was completed. These emergent transcript themes were clustered and organized into potential higher order or *superordinate themes*. A summary table of illustrative quotes and corresponding line numbers was created for each participant for the purpose of cross-referencing. Finally, themes from all transcripts were compared and clustered to form a list of superordinate themes, which conveyed the shared experience of participants. To ensure the themes were grounded in the data, similarities and differences were considered both within and between participants.

The Yardley (2000, 2008) criteria for ensuring quality in qualitative research were used throughout the study, with specific adaption for IPA as informed by Smith et al. (2009). The criteria include sensitivity to context, commitment and rigor, transparency and coherence, and impact and importance. Regular review using a quality assessment tool, developed by FW and MK, ensured these criteria were met at each stage of the research process.

A local network of IPA researchers completed independent analysis of sections of the data. The analyses were then compared to explore differences in interpretation, a process that allowed the elaboration and deeper exploration of the data. An audit trail of the analysis was checked by an independent IPA expert and each member of the research team (DL and MK). Therefore, a range of credibility checks based on multiple levels of analysis were conducted to ensure rigor.

IPA acknowledges the inherent tensions of the researcher’s potential influence over interpretation of the data (Smith et al., 2009). Therefore, the principle researcher completed a reflexive diary throughout the research process, to consider the potential influence on the research and for discussion in supervision. In addition, FW completed a bracketing interview with an IPA research group, before data collection, to identify underlying assumptions.

## Results

### *Overview*

The aim of this study was to explore the internal processes of recovery in psychosis from the first-person perspective. The analysis resulted in five superordinate themes that captured both shared and contrasting experiences of the participants. Table 2 provides the representation of

Table 2  
*Superordinate and Subordinate Themes*

Superordinate and subordinate themes	Total	Adam	Esther	Dean	Joe	Starr	James	Connor	Lisa	Maria	Bubbles
<b>1 "My mind can't take the load": the "curse" of psychosis</b>	<b>10</b>	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
1a The "extreme torture" of psychosis "destroys everything"	9	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
1b "I feel like some kind of freak," "looked down on" by powerful others—the stigma of psychosis	8	♦	♦	♦	♦	♦	♦		♦	♦	♦
1c "I couldn't cope": psychosis overwhelmed resources	3		♦						♦	♦	♦
1d "Plodding on" to "get your life back on track"	7	♦		♦	♦	♦		♦		♦	♦
1e "Blazing red signs": threat of relapse and threat to recovery	6			♦	♦	♦	♦				♦
<b>2 The "trap" of self-criticism</b>	<b>9</b>	♦		♦	♦	♦	♦	♦	♦	♦	♦
2a The "trap" of self-criticism	6	♦		♦	♦		♦	♦	♦	♦	♦
2b "It's all my fault": psychosis as a source of self-blame	4				♦	♦		♦		♦	♦
2c Putting self-criticism "behind bars"	5	♦		♦		♦	♦	♦	♦		♦
<b>3 "Coming to terms" with psychosis in my life to "move on"</b>	<b>10</b>	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
3a "No rhyme or reason to it"; "couldn't understand" psychosis	3							♦			♦
3b "Trying to figure out what was wrong"	7	♦	♦	♦	♦	♦	♦		♦		♦
3c "Feeling content" with self	6	♦		♦	♦	♦		♦	♦		♦
3d The challenge of "acceptance"	7	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
<b>4 "On my own two feet"</b>	<b>10</b>	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
4a Learning "to deal with it"	8		♦	♦	♦	♦	♦	♦	♦	♦	♦
4b "I helped put in the help"	9	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
4c "People try to help me"	7	♦	♦	♦	♦	♦		♦	♦	♦	♦
4d "I treated myself with kindness"	4						♦		♦	♦	♦
<b>5 "An opportunity" for growth</b>	<b>9</b>	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
5a "Life is worth living": finding hope for the future	5	♦	♦				♦		♦	♦	♦
5b "It's given me some important tools for life"	4								♦		♦
5c "I'm a lot, lot better": acknowledging progress in recovery	6			♦				♦		♦	♦

participants in the themes. Where possible, participants' words were used to label the themes to represent the essence of their experiences. The superordinate and related subordinate themes (noted in italics) are discussed in detail below. To ensure transparency, anonymized quotes are used to reflect participants' experiences.

1. "My mind can't take the load": The "curse" of psychosis.

The first superordinate theme captured the psychological burden of psychosis. All participants described (*1a*) the "extreme torture" of psychosis "destroys everything." Evocative language was used to capture the negative experience:

When you're ill, your brain is like full and you just can't get it back to normal. It's just crazy, everything's crazy, it drives you crazy. In your head, you hear people talking in your head. No, you can't be calm or collected when you are ill. It's just nuts. Your brain is thinking all kinds of weird stuff as well. (Lisa, 305)

Evocative language also described the effect of psychosis: "Psychosis basically destroys everything, your mental makeup, your whole fabric of your mind, it just destroys the lot" (Joe, 218).

The three female participants described experiences of being overwhelmed by psychosis in the subordinate theme (*1c*) "*I couldn't cope*": *psychosis overwhelmed resources*.

For nearly all participants, the powerful experience of psychosis affected their perception of themselves or how they believed others perceived them. (*1b*) "*I feel like some kind of freak*" and "*looked down on*" by powerful others—the stigma of psychosis captured the challenge that psychosis can pose to an individual's self-concept via external and internalized stigma. Participants reflected experiences of stigma: "By some people I'm kind of written off" (Esther, 352). In addition, social positioning was affected by psychosis: "You're at the bottom, climbing the rope to get up to be with other people" (Joe, 108).

Internalized stigma resulted in a challenge to participants' self-concept ("It's changed me, hasn't it. It's changed me"; Connor, 81); self-worth ("I feel really ashamed and I just feel like, like, like some kind of freak"; Esther, 358); and esteem ("I lost my confidence and I was thinking that there is something wrong with me"; Starr, 26). Separating one's self-concept from psychosis was identified as a potential strategy for protection against stigma and shame:

I try to make sure that I don't identify myself with it and, you know, build an ego structure around it. I try to make sure that I recognize that it is *part* of my situation, *not who I am essentially*. (James, 192)

Recovery from the negative experience of psychosis was described as a long and effortful journey—(*1d*) "*plodding on*" to "*get your life back on track*"—due to the distressing and powerful nature of psychosis. The aim of recovery—"just to be normal again" (Connor, 36)—required determination and perseverance: "Just plodding on when times are good, when times are bad, you've just got to plod on" (Adam, 443). Importantly, participants spoke more of their experiences in the process of recovery rather than defining recovery as an outcome. Of note, the findings of this study indicate that ways of relating to self, either critical or compassionate, affected the recovery process. For example, compassionate self-acceptance facilitated empowerment and agency for change to promote recovery: "You learn by one day doing a bit of a thing then next day adding another scenario, next day adding another scenario and building up on that" (Maria, 368).

Participants described being alert for (*1e*) "*blazing red signs*": *threat of relapse and threat to recovery*. A range of different threats to recovery was noted. Self-criticism was identified as a "blazing red sign" (James, 302) of relapse.

I criticise myself for having done that—"I shouldn't have done that. Why haven't I done that by now?"—and those kinds of things. Then I realize I'm going back down that same path again, down the breakdown path again. (Maria, 229)

Threats of relapse also caused dilemmas in the recovery process, for example, testing motivation: "It might be better to stay ill, but I don't want to stay ill" (Joe, 43). Other threats to recovery included the experience of hearing voices itself: "I know I'm getting better but the voices keep on saying 'no you're not'" (Bubbles, 56). These threats contributed to the challenging process of recovery from the distressing experience of psychosis.

## 2. The "trap" of self-criticism.

(2a) *The "trap" of self-criticism* reflects a reciprocal relationship between psychosis and self-criticism, which resulted in the maintenance of distress. Participants described self-criticism as a part of psychosis ("Self-judgment is part of the illness. So I'm very, I'm very alert to criticism as it comes up"; James, 289), which triggered or contributed to the development of psychosis ("I used to be critical of myself . . . harsh on myself, which is why I suppose I feel pressurized and became ill and stuff"; Maria, 242). Self-criticism had a powerful effect on participants, which led to increased risk to self or inhibition of action ("If you're critical about yourself you don't do it"; Adam, 241) and thus prevented recovery. However, psychosis was also a source of self-criticism, reflected in the subordinate theme (2b) *"it's all my fault": psychosis as a source of self-blame*:

I'd kind of blame myself and feel guilty for things that had happened. I'd said that if it hadn't been my fault, it wouldn't have happened. I kind of punished myself and I use a lot of guilt; I blame myself for a lot of the things that have gone wrong. I think if I had done it the right way round or that way round this wouldn't have happened, or that, so I kind of blame myself and feel guilt. (Joe, 413)

Thus, participants described a vicious cycle of psychosis triggering self-criticism and self-criticism perpetuating psychosis.

Participants in this study described a distinction between self-criticism and hearing voices: "These are *my* voices in *my* head, not the voices out there" (Lisa, 251). An intricate relationship also emerged in which the voices triggered criticism: "All the voices would be saying, 'Look at what he's done', 'cos the voice would notice and then I would notice it" (Dean, 306).

Half of the participants described (2c) *putting self-criticism "behind bars,"* developing strategies to cope with and protect themselves from self-criticism. This included adjusting to self-criticism, "I've just um, hardened to it" (Dean, 302), and efforts to actively respond, "I try and push it back a bit" (Connor, 154). Lisa described the development of a benevolent voice to encourage self-belief and facilitate recovery.

## 3. "Coming to terms" with psychosis in my life to "move on."

The dual process of acceptance, of psychosis and of self, was central to participants' accounts of recovery: "The first thing I listed was acceptance, because you really can't do anything if you don't align yourself with the situation first" (James, 165). Acceptance was characterized as a learning process that facilitated change and improvement: "When I've had my relapses I've gone back and we try and figure out new stuff, and so, we're getting there" (Adam, 80). However, three participants described (3a) *"no rhyme or reason to it": "couldn't understand" psychosis*.

Participants' described a change in their intrapersonal relationship, noted in the subtheme (3c) *"feeling content" with self*. Lisa stated, "Well, I don't hate myself anymore. I used to hate myself . . . I used to tell myself I'm ugly. I used to hit myself in the face, bang my head against the wall, uh, everything." (143). For some, this change included an improved sense of self-worth:

Along with psychologically not feeling so poorly, not feeling so inferior, so low, um, starting to go, get a bit more self-esteem. Starting to get a little more confident, a bit, not totally confident but trying to work out the avenues and the ways to get myself back to as normal as can be. (Joe, 83)

This process of self-acceptance appeared to be implicit. Connecting with others facilitated acceptance of psychosis and of self: "You just learn that all people have got problems, some



more than others” (Bubbles, 138). However, “justifying” this contentment was challenging: “What have I done to deserve to be kind to myself” (Joe, 470).

(3d) *The challenge of “acceptance”* captured the demanding but necessary nature of acceptance: “If you can’t accept it, then you can’t get help” (Esther, 30). Bubbles noted: “It’s quite hard coming to terms with, ‘Well, you’ve got this for the rest of your life, so get on with it’, because basically that’s what it is, that’s the long and short of it” (50). Finding the balance between accepting psychosis as a part of one’s life experiences without it reflecting one’s self-concept was described as particularly challenging: “The voice isn’t a separate personality, it’s me. But it’s hard to realize that because nobody wants to think it’s you, or your conscious or your subconscious or whatever” (Dean, 256).

#### 4. "On my own two feet."

Acceptance led to a sense of self-reliance for recovery: “You know, you’re the only one really who can make yourself better, not other people around you” (Adam, 166). However, acting upon this realization of agency was described as demanding: “I’ve got to help myself . . . I just find it hard” (Connor, 66).

Participants described (4a) *learning “to deal with it”* and developing ways to cope including distraction via music or engaging with others. Sometimes this was spontaneous or natural (“They just popped up”; Lisa, 264), while for others this was the deliberate attempt to acquire skills to cope. Coping was seen as individualistic but more likely that others *might* cope in similar ways: “Of course there might be some things that I’ve done that might help or not help other people, but it’s horses for courses” (Dean, 364). The process of adapting may reflect the resilience of participants to cope with the “curse” (Connor, 107) of psychosis.

As self-reliance increased, confidence and self-belief improved, resulting in a more coherent and positive self-concept: “I think the more I do things it makes me feel good inside, makes me alive. That’s it, I’m alive I feel alive and in control, strong, that’s how I feel” (Lisa, 177). This is noted in subtheme (4b) *“I helped put in the help.”*

Once again, the importance of social relationships in the process of acceptance and recovery was noted by participants in the subordinate theme (4c) *“people try to help me”*:

They did encourage me, like, not just encourage me, they said you have got these properties in you; you are that type of person or something. Even my colleagues, other clients, like people who are on medication; they did help me a lot with this also. (Starr, 340)

Relationships with professionals also facilitated recovery. Although only two participants had received individual psychological therapy, they identified it as a catalyst for change: “In therapy being able to talk through it and when you start to talk through it you start to analyze what’s going on in your life and start, then you start to take little steps” (Dean, 26).

In the subordinate theme (4d) *“I treated myself with kindness,”* participants’ described their emotional response to themselves: “I was being kind to myself, and then I started to learn to get the hang of things again and learn to put things in perspective” (Maria, 329). The internal quality of this change was important: “I think it’s in my mind, its, if I’m happy inside then I can bear stress, I can be happy outside also” (Star, 202).

However, psychosis was identified as a barrier to self-compassion: “No, you can’t be kind to yourself when you’re ill” (Lisa, 304). Furthermore, psychosis was identified as a result of limited self-compassion or kindness: “When things are going less well that’s really symptomatic of the fact that you haven’t really been being very kind to yourself” (James, 372). These results highlight how the emotional texture of the intrapersonal relationship affects recovery.

One participant spoke explicitly about the nature of compassion as reciprocal and mutual:

I guess being compassionate to yourself kind of implies that you are two different people; one who is being compassionate and one who is appreciating the compassion, but really it is more a holistic thing. If you are feeling compassion for others,

then you feel it yourself as well naturally and you almost just, you know, just become compassionate in total. (James, 414)

##### 5. "An opportunity" for growth.

Despite the severe and enduring nature of their experiences, participants spoke of developing hopeful plans for the future and opportunities for growth. Participants described discovering (5a) "*life is worth living*": *finding hope for the future*: "I understand that I have an illness, and know that it might be a lifelong illness, but it doesn't mean it can stop me from, you know, pursuing my dreams" (Esther, 264).

Half the participants described psychosis as resulting in some positive benefits: (5b) "*It's given me some important tools for life*" (Bubbles, 144). This included social opportunities, for example, "I've made new friends, very lifelong friends, and I wouldn't have had them before, and that has helped me as well" (Maria, 402), and internal changes, "It's made me more compassionate and understanding of mental illness. It's also given me an opportunity to start again" (James, 404).

Participants acknowledged their progress in recovery with an awareness of the ongoing journey. (5c) "*I'm a lot, lot better*": *acknowledging progress in recovery* included connecting with others and developing a sense of safeness, for example, "[I was] able to talk about it and work through it means I'm starting to become well and not afraid" (Joe, 60).

### *Summary*

The first superordinate theme highlighted the distressing experience of psychosis and the effortful process of recovery, which included overcoming both psychotic symptoms and shame associated with psychosis. The second superordinate theme identified a reciprocal relationship, between psychosis and self-criticism, which perpetuated distress and inhibited recovery. The third superordinate theme identified the dual process of acceptance of self and acceptance of psychosis. The fourth superordinate theme reflected participants' accounts of empowerment and action for change in their lives. The final superordinate theme related to growth and hope for the future. Together, the themes represent participants' accounts of an internal process of recovery in psychosis.

## Discussion

### *Overview*

The findings of this study fit with extensive research indicating the complex and multifaceted concept and process of recovery in psychosis (Bird et al., 2011). The way in which the emotional texture of the intrapersonal relationship may influence this recovery process offers a useful addition to existing literature. Further to this, the findings regarding posttraumatic growth (PTG) provide a broader account of the experience of psychosis. It is these novel features that are the focus of this discussion.

### *Understanding Recovery*

The findings of this study fit well with the processes of recovery proposed by Andresen, Oades, and Caputi (2003): finding hope, reestablishment of identity, finding meaning in life, and responsibility for recovery. However, the current findings indicate an iterative rather than linear pattern between the internal processes of recovery. Participants reported that as self-reliance increased, confidence and self-belief also improved, resulting in a more coherent and positive self-concept. This iterative process may reflect a helpful maintenance cycle.

Existing patient accounts of recovery identify the influence of self-concept, the importance of self-acceptance, and the challenge of overcoming internalized stigma (e.g., Coleman, 2000). In a user-led IPA study of recovery, Pitt, Kilbride, Nothard, Welford, and Morrison (2007) reported

themes of rebuilding self, rebuilding life and hope for a better future. Pitt's study indicated that increased self-awareness was necessary for progress in recovery. Pitt and colleagues (2007) note, "The development of a new sense of self can lead to the establishment of a fulfilling life, whether or not symptoms are present" (p. 57). Notably, these patient accounts highlight the importance and challenge of developing a compassionate relationship with oneself to facilitate recovery: "The real task in all of this is to somehow learn to value yourself. That can seem like such an impossible thing to do because you get so bombarded with messages and images that are so negative and degrading" (Deegan, 1997, p. 23). The current findings support these existing accounts, which suggest that relationship with self is a fundamental part of the process of recovery.

### *Relationship With Self*

Consistent with existing literature (e.g., Corrigan & Watson, 2002) internalized stigma resulted in a challenge to participants' self-concept. Participants described a struggle to preserve a sense of being a person "who *has* but *is not* an illness" (Estroff, 1989, p.193). Thus, it follows that recovery involves finding ways to manage not only the symptoms of psychosis but also the external and internal shame of psychosis. Gilbert (2009b) reports that it is the "fear of rejection and of being looked down on that really drives self-criticism" (p. 358); the experiences of stigma reflected in the first superordinate theme may account for the prevalence of self-criticism in this study.

In the current study, participants described a vicious cycle of psychosis triggering self-criticism and self-criticism perpetuating psychosis. This may reflect maintenance cycle processes proposed in other shame-based reactions, for example, in posttraumatic stress disorder (Lee, 2005, 2009). Previous research has identified a potential reciprocal relationship between hearing voices and negative core beliefs about the self, in which behavioural and affective responses may serve to confirm negative beliefs about the self (Smith et al., 2006).

In addition, negative evaluation of the self has been related to increased rates of relapse (Holding, Tarrier, Gregg, & Barrowclough, 2013). Hateful self-attacking, a particular form of self-criticism or way of relating to oneself, may be involved in the development or maintenance of persecutory delusions (Hutton et al., 2013). Levels of self-criticism and capacity to self-reassure have been linked to the content and experience of voice hearing (Connor & Birchwood, 2013). Therefore, the current findings strengthen the existing literature to indicate a powerful interaction between relationship with self and distressing experiences of psychosis, including hearing voices and persecutory delusions. Consideration of the interaction between self-criticism, hearing critical voices, persecutory ideas, and beliefs about the self could be a helpful focus for future research.

The concept of redefining identity and reconstructing a sense of self has been noted in review studies (Bonney & Stickley, 2008) and IPA research (Windell, Norman, & Malla, 2012). In line with previous findings, this effortful process of developing understanding and reconstruction of self enabled individuals to "move forward" (Davidson & Strauss, 1992). The emotional tone of this process of acceptance is highlighted in this study and may relate to developments in the concept of compassionate self-acceptance. Compassionate self-acceptance includes the view that psychosis may be seen as a part of one's life experiences but not reflecting their sense of who they are as a person. This enables the engagement of the soothing and contentment system in the face of threat (Gilbert, 2009b), including self-criticism and shame (Gilbert & Proctor, 2006) and threats in recovery after psychosis (Gumley et al., 2010). Higher levels of self-compassion have been correlated with reduced symptoms of psychosis (Eicher et al., 2013).

The findings of this study can be understood in the theoretical framework proposed by Gumley and colleagues (2010), that compassionate responding may alleviate threat-based strategies, tone down the effect of self-criticism, and promote recovery after psychosis through self-acceptance. Therefore, the relationship with the self, and particularly the emotional tone of this relationship, may influence this internal process of recovery in psychosis.

### Posttraumatic Growth

The novel finding in this study—that individuals who have experienced severe and enduring psychosis also report PTG—is particularly interesting given the duration of the negative life event. Participants reported PTG in the domains of personal strength, recognition of new possibilities, closer relationships, and appreciation of life (Tedeschi & Calhoun, 2004). The continued presence of distressing experiences of psychosis supports the notion that distress and growth are separate constructs that can coexist (Calhoun, Cann, & Tedeschi, 2010).

It has been suggested that focus on PTG may broaden the concept of recovery, increase hope, and decrease wider societal stigma relating to the perceived negative consequences of psychosis (Dunkley, Bates, Foulds, & Fitzgerald, 2007). It may be that the process of recovery in psychosis is not about returning to prior functioning; rather, it is about moving forward, or even moving beyond, and relationship with self might influence this capacity for growth. Therefore, despite ongoing experiences of psychosis, growth may be a focus of treatment to promote more fulfilling lives. It is unclear, at present, if growth could result in reduced distress and effect of psychosis; however, the exciting prospect of this reflection calls for further research.

### Proposed Representation of the Internal Process of Change in Recovery in Psychosis

In the complex process of recovery, it is likely that specific factors interact to prevent or promote change. Therefore, consideration has been given to how the themes identified in the current study may interact to influence the process of change. Aspects of the themes identified in the current study have been used to inform the following representation of the internal process of change in psychosis recovery (see Figure 1). In line with the philosophical underpinnings of IPA, this representation is not outlined as a generalizable model; rather, it reflects consideration of how the themes from this study may be understood as a whole to represent a process of change. This is proposed as a reflective and discursive representation and is not proposed as a quantitatively tested model.

Two maintenance cycles are hypothesized to influence the internal process of recovery in psychosis:

1. The maintenance cycle of distress: The negative experience of psychosis and stigmatizing reactions from others may result in or maintain a negative sense of self and self-criticism. In turn, this may contribute toward further experiences of psychosis. The negative experience of psychosis and others reactions speaks to superordinate theme one and the experience of self-criticism speaks to superordinate theme two.
2. The maintenance cycle of well-being or recovery: The development of compassionate self-acceptance can lead to a sense of empowerment, hope, and belief in one's capacity to cope with

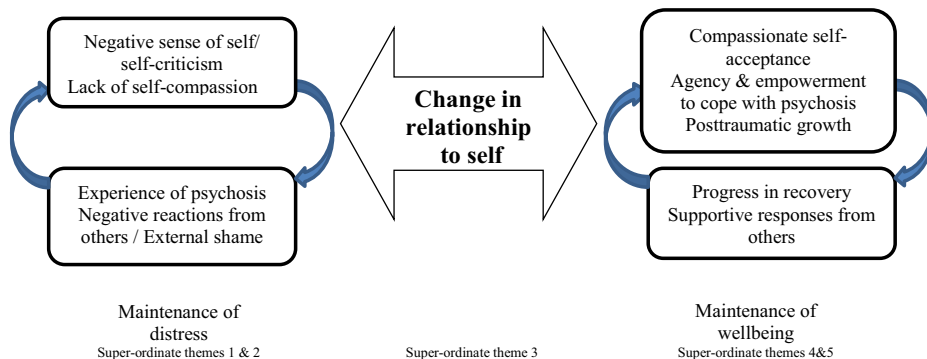


Figure 1. A representation of the hypothesized internal process of change in relationship with self in recovery in psychosis.

- psychosis. This may result in progress in recovery and supportive responses from others. In turn, this may lead to a greater capacity to relate to oneself with compassion and potentially result in PTG. The increasing empowerment and noting recovery speaks to superordinate theme four and the potential for growth speaks to superordinate theme five.
3. It is proposed that a change in relationship to self via a process of acceptance mediates the two maintenance cycles. The process of acceptance speaks to superordinate theme three.

The proposed process fits with the current literature including models related to recovery in psychosis (Gumley et al., 2010), development of self-compassion (Eicher et al., 2013; Gilbert, 2009b), and PTG (Tedeschi & Calhoun, 2004). However, it should be explicitly noted that the proposed representation is based on the findings of a very small, purposively sampled homogenous group and is intended for theoretical consideration only.

### *Implications*

A number of clinical implications are indicated. One of them is the potential value of therapeutic work which considers the emotional texture of the relationship with the self and focuses on the development of a coherent and compassionate sense of self to promote recovery. It has been proposed that recovery involves overcoming both the symptoms and the shame of psychosis. Research indicates that developing self-compassion or compassionate self-acceptance is the psychological antidote to shame (Gilbert, 2005). Hence CFT, with its emphasis on the development of self-compassion, may offer a fruitful approach to facilitate recovery in psychosis.

As noted in brief case studies (Laithwaite et al., 2009; Mayhew & Gilbert, 2008) and feasibility studies (Braehler et al., 2013), this study supports the application of CFT in psychosis. The National Institute for Health and Clinical Excellence (NICE) recommends the use of cognitive behavioural therapy for psychosis (CBTp) and define the aim of CBTp: "To help the individual normalise and make sense of their psychotic experiences, and to reduce the associated distress and impact on functioning" (NICE, 2009, p. 258). The themes in the current study centre on negative self-relating and how this may maintain distressing psychotic symptoms; therefore, negative-self-cognitions and affect are identified as valid and important treatment targets in psychological therapy. The reduction of negative cognitions about the self has been the focus of recent developments in CBTp (Freeman et al., 2014). The current study, therefore, lends support to the application of CBTp and therapies that promote acceptance and compassion to facilitate recovery in psychosis.

On a broader level, implications from this study include the development of empowering services that facilitate narratives of hope to facilitate PTG, as recognized in policy documents, which support the development of recovery oriented services (Shepherd, Boardman, & Slade, 2008). For example, the participants' accounts highlight the value of interacting with other service users. For services this may mean the development of peer support or peer experts to facilitate others recovery. On a societal level, the participants in this study continue to echo calls to reduce stigma. Therefore, clinical implications on a number of levels have been identified and encourage the development of services in collaboration with service users.

A number of areas for future research have been identified. These include the exploration of the intricate relationship between self-criticism and psychosis, including the experience of voice hearing. Explorations of how the different types of self-criticism and self-reassurance interact with critical voices would inform models of voice hearing and CFT. The clinical application of CFT in psychosis demands research to demonstrate the effectiveness of the intervention and identify the mechanisms of change.

### *Limitations*

A significant limitation of this study was the explicit focus on processes of recovery rather than precursors or causes of psychosis. Previous research has indicated self-criticism may be present in a range of psychological difficulties, including psychosis (Gilbert & Irons, 2005). Therefore, it is unclear, at present, if the self-criticism reported in this study was present prior to psychosis, or

triggered by psychosis. Self-criticism appears to be an important maintenance factor in negative experiences of psychosis, which impedes recovery. It is unclear, however, based on the findings of this study, if self-criticism may precede or contribute to psychosis as well as result from psychosis.

Despite efforts to create a homogenous sample, the participants had a range of cultural backgrounds. This may have influenced their understanding and expression of the concepts explored in the interview. James was the only participant to mention the specific word “compassion” in his interview, whereas other participants used kindness, contentment, and esteem. This suggests that the term compassion may lack meaning to individuals with psychosis and this has implications for engaging individuals in CFT. The identification of aspects of PTG and compassion in these accounts reveals the need to explore the potential effect of religious and spiritual experiences regarding how people make sense of their experiences.

### Conclusion

The key findings of this study indicate psychosis is a distressing experience and recovery involves overcoming not only the symptoms of psychosis but also the internal and external shame associated with psychosis. A reciprocal relationship between psychosis and self-criticism emerged, which maintained distress and prevented recovery. Self-criticism was subjectively experienced as distinct from critical voices and for some breaking the cycle of self-criticism was a natural process that facilitated recovery. The process of acceptance, of psychosis and self, was identified as both challenging and necessary. Others facilitated this natural process of compassionate self-acceptance. Empowered action, self-belief, and acceptance promoted a positive maintenance cycle, which fostered recovery and for some growth. The novel finding that despite the severe and enduring nature of psychosis, participants experienced PTG which offers hope and demands for services to actively promote growth in spite of ongoing distress.

This study represents the first exploration of experiences of self-criticism, self-compassion, and PTG in recovery from the perspective of people with prolonged experiences of psychosis. In line with previous research, this study reported the effortful process of recovery from severe and distressing psychosis. Participants described experiences of growth, a novel finding in the field of enduring psychosis. The themes identified fit with existing models of recovery. However, the findings also offer an insight in to the internal processes associated with recovery. Breaking the cycle of psychosis and self-criticism, through a process of compassionate self-acceptance, may facilitate recovery in psychosis. The findings of this study fit with an emerging constellation of evidence that suggests the principles of CFT may facilitate recovery in psychosis.

### References

- Andresen, R., Oades, L., & Caputi, P. (2003). The experience of recovery from schizophrenia: Towards and empirically validated stage model. *Australian and New Zealand Journal of Psychiatry*, *37*, 586–594. doi:10.1046/j.1440-1614.2003.01234.x
- Birchwood, M., Trower, P., Brunet, K., Gilbert, P., Iqbal, Z., & Jackson, C. (2006). Social anxiety and the shame of psychosis: A study in first episode psychosis. *Behavior and Research Therapy*, *45*, 1025–1037. doi:10.1016/j.brat.2006.07.011
- Bird, V., Leamy, M., LeBoutillier, C., Williams, J., & Slade, M. (2011). *REFOCUS: Promoting recovery in community mental health services*. London: Rethink.
- Bonney, S., & Stickley, T. (2008). Recovery and mental health: A review of the British literature. *Journal of Psychiatric and Mental Health Nursing*, *15*, 140–153 doi:10.1111/j.1365-2850.2007.01185.x
- Braehler, C., Gumley, A., Harper, J., Wallace, S., Norrie, J., & Gilbert, P. (2013). Exploring change processes in compassion focused therapy in psychosis: Results of a feasibility randomized controlled trial. *British Journal of Clinical Psychology*, *52*, 199–214. doi:10.1111/bjc.12009
- Calhoun, L. G., Cann, A., & Tedeschi, R. G. (2010). The posttraumatic growth model: Sociocultural considerations. In T. Weiss & R. Berger (Eds.), *Posttraumatic growth and culturally competent practice: Lessons learned from around the globe* (pp. 1–14). Hoboken, NJ: Wiley and Sons.
- Coleman, R. (2000). *Recovery, an alien concept?* Gloucester: Handsell.

- Connor, C., & Birchwood, M. (2013). Through the looking glass: Self-reassuring meta-cognitive capacity and its relationship with the thematic content of voices. *Frontiers in Human Neuroscience*, 7, 1–8. doi:10.3389/fnhum.2013.00213
- Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice*, 9, 35–53. doi:10.1093/clipsy.9.1.3
- Davidson, L., & Strauss, J. S. (1992). Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology*, 65, 131–145. doi:10.1111/j.2044-8341.1992.tb01693.x
- Deegan, P. E. (1997). Recovery and empowerment for people with psychiatric disabilities. *Social Work in Health Care*, 25(3), 11–24. doi:10.1300/J010v25n03\_02
- Dunkley, J. E., Bates, G. W., Foulds, M., & Fitzgerald, P. (2007). Understanding adaptations to first-episode psychosis: The relevance of trauma and posttraumatic growth. Retrieved from <http://www.massey.ac.nz/~trauma/issues/2007-1/dunkley.htm>
- Eicher, A. C., Davis, L. W., & Lysaker, P. H. (2013). Self-compassion: A novel link with symptoms in schizophrenia? *The Journal of Nervous and Mental Disease*, 201(5), 389–393. doi:10.1097/NMD.0b013e31828e10fa
- Estroff, S. E. (1989). Self, identity, and subjective experiences of schizophrenia: In search of the subject. *Schizophrenia Bulletin*, 15(2), 198–196. doi:10.1093/schbul/15.2.189
- Freeman, D., Pugh, K., Dunn, G., Evans, N., Sheaves, B., Waite, F., . . . Fowler, D. (2014). An early Phase II randomised controlled trial testing the effect on persecutory delusions of using CBT to reduce negative cognitions about the self: The potential benefits of enhancing self confidence. *Schizophrenia Research*. doi:10.1016/j.schres.2014.10.038
- Gilbert, P. (Ed.). (2005). *Compassion: Conceptualizations, research and use in psychotherapy*. London: Routledge.
- Gilbert, P. (2009a). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment*, 15, 199–208. doi:10.1192/apt.bp.107.005264
- Gilbert, P. (2009b). *The compassionate mind*. London: Constable Robinson.
- Gilbert, P. (2010). *Compassion focused therapy: Distinctive features*. London: Routledge.
- Gilbert, P., Birchwood, M., Gilbert, J., Trower, P., Hay, J., Murray, B., . . . Miles, J. M. (2001). An exploration of evolved mental mechanisms for dominant and subordinate behavior in relation to auditory hallucinations in schizophrenia and critical thoughts in depression. *Psychological Medicine*, 31, 1117–1127. Retrieved from: <http://www.ncbi.nlm.nih.gov/pubmed/11513379>
- Gilbert, P., & Irons, C. (2005). Focused therapies and compassionate mind training for shame and self-attacking. In P. Gilbert (Ed.), *Compassion: Conceptualizations, research and use in psychotherapy* (pp. 326–351). London: Routledge.
- Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group approach. *Clinical Psychology and Psychotherapy*, 13, 353–379. doi:10.1002/cpp.507
- Goss, K., Gilbert, P., & Allan, S. (1994). An exploration of shame measures: I: The ‘other as shamer’ scale. *Personality and Individual Differences*, 17, 713–717. Retrieved from <http://www.compassionatemind.co.uk/resources/other+as+shamer+scale.doc>
- Gumley, A., Braehler, C., Laithwaite, H., MacBeth, A., & Gilbert, P. (2010). A compassion focused model of recovery after psychosis. *International Journal of Cognitive Therapy*, 3, 186–201. doi:10.1521/ijct.2010.3.2.186
- Hasson-Ohayon, I., Ehrlich-Ben Or, S., Vahab, K., Amiaz, R., Weiser, M., & Roe, D. (2012). Insight into mental illness and self-stigma: The mediating role of shame proneness. *Psychiatry Research*, 200(2-3), 802–806. doi:10.1016/j.psychres.2012.07.038
- Hayward, P., & Bright, J. A. (1997). Stigma and mental illness: A review and critique. *Journal of Mental Health*, 6(1), 345–354. doi:10.1080/09638239718671
- Holding, J. C., Tarrier, N., Gregg, L., & Barrowclough, C. (2013). Self-esteem and relapse in schizophrenia: A 5-year follow-up study. *Journal of Nervous and Mental Disease*, 201(8), 653–658. doi:10.1097/NMD.0b013e31829c4ffc
- Hutton, P., Kelly, J., Lowens, I., Taylor, P., & Tai, S. (2013). Self-attacking and self-reassurance in persecutory delusions: a comparison of healthy, depressed and paranoid individuals. *Psychiatry Research*, 205, 127–136. doi:10.1016/j.psychres.2012.08.010
- Iqbal, Z., Birchwood, M., Chadwick, P., & Trower, P. (2000). Cognitive approach to depression and suicidal thinking in psychosis. *British Journal of Psychiatry*, 177, 522–528. doi:10.1192/bjp.177.6.522

- Kelly, A. C., Zuroff, D. C., & Shapira, L. B. (2009). Soothing oneself and resisting self-attacks: The treatment of two intrapersonal deficits in depression vulnerability. *Cognitive Therapy and Research*, 33, 301–313. doi:10.1007/s10608-008-9202-1
- Kelly, M., & Gamble, C. (2005). Exploring the concept of recovery in schizophrenia. *Journal of Psychiatric and Mental Health Nursing*, 12, 245–251. doi:10.1111/j.1365-2850.2005.00828.x
- Knight, M. T. D., Wykes, T., & Hayward, P. (2003). 'People don't understand': An investigation of stigma in schizophrenia using interpretative phenomenological analysis (IPA). *Journal of Mental Health*, 12, 209–222. doi:10.1080/0963823031000118203
- Laithwaite, H., O'Hanlon, M., Collins, P., Doyle, P., Abraham, L., Porter, S., & Gumley, A. (2009). Recovery after psychosis (RAP): A compassion focused programme for individuals residing in high security settings. *Behavioral and Cognitive Psychotherapy*, 37, 511–526. doi:10.1017/S1352465809990233
- Lee, D. (2005). The perfect nurturer: A model to develop a compassionate mind within the context of cognitive therapy. In P. Gilbert (Ed), *Compassion: Conceptualizations, research and use in psychotherapy* (pp. 326–351). London: Routledge.
- Lee, D. (2009). Compassion-focused cognitive therapy for shame-based trauma memories and flashbacks in post-traumatic stress disorder. In N. Grey (Ed), *A casebook of cognitive therapy for traumatic stress reactions* (pp. 230–246). London: Routledge.
- Mashiach-Eizenberg, M., Hasson-Ohayon, I., Yanos, P. T., Lysaker, P. H., & Roe, D. (2013). Internalized stigma and quality of life among persons with severe mental illness: The mediating roles of self-esteem and hope. *Psychiatry Research*. doi:10.1016/j.psychres.2013.03.013
- Mayhew, S. L., & Gilbert, P. (2008). Compassionate mind training with people who hear malevolent voices: A case series report. *Clinical Psychology and Psychotherapy*, 11, 113–138. doi:10.002/cpp.566
- National Institute for Health and Clinical Excellence. (2009). *Schizophrenia: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care. (CG82)*. London: Department of Health.
- Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. *Self and Identity*, 2, 223–250. doi:10.1080/15298860390209035
- Neff, K. D., Kirkpatrick, K. L., & Rude, S. S. (2007). Self-compassion and adaptive psychological functioning. *Journal of Research in Personality*, 41, 139–154. doi:10.1016/j.jrp.2006.03.004
- Neff, K. D., & McGehee, P. (2010). Self-compassion and psychological resilience among adolescents and young adults. *Self and Identity*, 9, 225–240. doi:10.1080/15298860902979307
- Pitt, L., Kilbride, M., Nothard, S., Welford, M., & Morrison, A. P. (2007). Researching recovery from psychosis: A user-led project. *Psychiatric Bulletin*, 31, 55–60. doi:10.1192/pb.bp.105.008532
- Perry, B. M., Taylor, D., & Shaw, S. K. (2007). "You've got to have a positive stage of mind": An interpretative phenomenological analysis of hope and first episode psychosis. *Journal of Mental Health*, 16, 781–793. doi:10.1080/09638230701496360
- Romano, D. M., McCay, E., Goering, P., Boydell, K. M., & Zipursky, R. (2010). Reshaping an enduring sense of self: The process of recovery from a first episode of schizophrenia. *Early Intervention in Psychiatry*, 4, 243–250. doi:10.1111/j.1751-7893.2010.00187x
- Shepherd, G., Boardman, J., & Slade, M. (2008). *Making recovery a reality*. London: Sainsbury Centre for Mental Health.
- Smith, B., Fowler, D. G., Freeman, D., Bebbington, P., Bashforth, H., Garety, P., Dunn, G., & Kuipers, E. (2006). Emotion and psychosis: Links between depression, self-esteem, negative schematic beliefs and delusions and hallucinations. *Schizophrenia Research*, 86(1), 181–188. doi:10.1016/j.schres.2006.06.018
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology & Health*, 11, 261–271. doi:10.1080/08870449608400256
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.
- Tantam, D. (1998). Chapter 8: The emotional disorders of shame. In Gilbert, P. & Andrews, P. (Eds.), *Shame: Interpersonal behavior, psychopathology and culture* (pp. 161–175). Oxford: Oxford University Press.
- Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry: An International Journal for the Advancement of Psychological Theory*, 15(1), 1–18. doi:10.1207/s15327965pli1501\_01
- Turner, M. H., Bernard, M., Birchwood, M., Jackson, C., & Jones, C. (2013). The contribution of shame to post-psychotic trauma. *British Journal of Clinical Psychology*, 52(2), 162–182. doi:10.1111/bjc.12007



- Windell, D., Norman, R., & Malla, A. K. (2012). The personal meaning of recovery among individuals treated for a first episode of psychosis. *Psychiatric Services, 63*(6), 548–553. doi:10.1176/appi.ps.201100424
- World Health Organization. (2001). *World health report 2001. Mental health: New understanding, new hope*. Geneva: Author.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15*, 215–228. doi:10.1080/08870440008400302
- Yardley, L. (2008). Chapter 11: Demonstrating validity in qualitative psychology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2nd ed., pp. 53–80). London: Sage.