



Socially differentiated life trajectories of individuals with experience of psychosis: A biographical study

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ABSTRACT

The role of social factors in the development and course of psychotic disorders has been increasingly acknowledged in recent decades. The present study examines the role of social, family and environmental factors in shaping biographical trajectories of people experiencing psychosis. Biographical interviews were conducted with 27 individuals with experience and diagnosis of psychotic disorders, in several locations in Greece. The narratives were subjected to biographical analysis, culminating in the formation of five biographical types, characterized by stigma, chronicity, marginalization, suffering and defiance. Early recognition and community management of distress were found to distinguish participants with more favorable therapeutic itineraries. Availability of community mental health services, access to empowering popular and professional discourses and participation in interpersonal relationships and social networks seem to exercise positive influence, while internalized social stigma, possibly related to primary socialization in restrictive familial environments, and lack of access to resources can be detrimental.

1. Introduction

The role of social factors in the development of psychotic disorders has been extensively documented (Shah, Mizrahi, & McKenzie, 2011; van Os, Kenis, & Rutten, 2010). Epidemiological research has examined the role of socioeconomic disadvantage, poverty, homelessness, urban upbringing, migration and minority status in the development of psychotic disorders (Kirkbride et al., 2017; Richardson, Hameed, Perez, Jones, & Kirkbride, 2018; Stilo, di Forti, & Murray, 2011; Tarricone et al., 2015). There is growing evidence for an association between childhood traumatic experiences, such as abuse, neglect and victimization, adverse childhood experiences, including poverty and inappropriate living conditions, family disorganization and conflict, separation from parents, as well as problematic early attachment experiences and the subsequent emergence of psychotic experiences (Bentall et al., 2014; Fusar-Poli et al., 2017; Shevlin et al., 2016; van Winkel et al., 2013). Research has also highlighted mediating mechanisms, for example forms of socialization, access to resources and social support, through which socioeconomic factors affect mental health, as well as the relation between social structural factors and personal understandings and strategies of action (Dillon, 2011; Zissi, 2013).

The role of social factors in the course of psychosis has been much

less investigated, partly due to the persistence of the Kraepelinian assumption that psychosis is a chronic condition with deteriorating course (Zipurski, Reilly, & Murray, 2013). Several longitudinal studies in recent decades have established that the course of psychotic disorders is highly variable, ranging from progressive deterioration to complete restoration of functioning, with various combinations of periods of intensified mental distress and periods of partial or full remission of symptoms for most sufferers (AlAqeel & Margolese, 2012; Jääskeläinen et al., 2013; Lally et al., 2017). Age of onset, type and intensity of symptoms, prior levels of functioning, early trajectory of psychotic experiences and duration of untreated psychosis have all been found to correlate with long-term course (Díaz-Caneja et al., 2015; Power, 2017). The consistent finding of more favorable outcome of psychosis in developing countries (Hopper et al., 2007) has led to discussions of the possible positive contribution of family involvement and extended family support, community cohesion and social integration, less stigma due to popular beliefs regarding distress, employment opportunities through accommodating work regimes and availability of various community healing options (Hopper, 2008). There are indications that in developed countries adverse social conditions, such as unemployment, poverty, homelessness and social isolation negatively impact on the course of psychosis (Warner, 2008). Despite increasing research on the factors influencing the course of psychosis, the contributors to the

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World Health Organization International Study of Schizophrenia, which traced recovery from psychosis over 25 years in several countries, note that the sociocultural factors that account for the major discrepancies in the course and outcome of psychosis between the study centers are yet to be identified and conclude that “future studies will require both qualitative and quantitative methods to explore the characteristics of environment that promote recovery” (Harrison et al., 2001: 515).

Research findings regarding the variable course of psychosis, in conjunction with testimonies of recovery and pressure from the user movement, brought to the foreground the notion of recovery from severe mental distress (Slade et al., 2014). The central tenets of recovery seem to be hope and optimism for the future, empowerment and control over one's life, rebuilding positive personal and social identities, and finding meaning and purpose in life (Amering & Schmolke, 2009; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Having supportive relationships with family, friends and intimate partners is considered crucial for recovery, as well as engaging in socially valued roles and activities and having a sense of belonging to communities, in the mental health field and beyond (Tew et al., 2012; Topor et al., 2006).

The past few decades have also witnessed a renewed interest in the lived experience of psychosis, including phenomenological depictions of the psychotic experience (Sass & Parnas, 2003), narrative and dialogical investigations of the constitution of the self in psychosis (Lysaker & Lysaker, 2008) and discourse analytic studies of the social construction of psychosis (Georgaca, 2014). A large corpus of qualitative studies has investigated the views of individuals with psychosis on the experience of psychosis, its impact on their lives, various aspects of life with psychosis, their explanatory models as well as evaluation of treatments and services (de Jager et al., 2015; Georgaca, 2013; McCarthy-Jones, Marriott, Knowles, Rowse, & Thompson, 2013).

The present study is grounded upon, and aims to bring together, the above research trends. It attempts to combine an understanding of the lived experience of psychosis with an examination of the social factors that have shaped it. Moreover, by tracing the biographical trajectories of individuals with experience of psychosis, it aims to highlight the role of social factors in the process of recovering from severe mental distress. More specifically, drawing upon the biographical paradigm, the study focuses on the factors that turned adverse life experiences to a ‘dependent biographical trajectory’ (Schütze, 1999), a life course in which specific experiences of suffering become central in shaping one's life and identity.

Given the debates regarding the validity and utility of the syndrome-based biomedical approach to schizophrenia and other psychotic disorders (Bentall, 2004), in line with recent trends (British Psychological Society, 2014), we use the term ‘psychosis’ to refer to a range of experiences that would be considered in the dominant paradigm as symptoms of severe mental disorders. In this paper, the term ‘psychotic experiences’ denotes experiences of intense mental distress, while the term ‘psychiatric experiences’ denotes experiences of treatment within the mental health service system.

2. Method

2.1. Purpose and rationale

The study methodologically adopted the biographical approach (Chamberlayne, Bornat, & Wengraf, 2000; Miller, 2000), which focuses on the historically formed as well as socially and materially constituted subjectivity. On the one hand, the biographical approach investigates the narrator's lived life story. By this we refer to the social conditions and events that have influenced a subject's life and the ways in which the subject experienced, understood and acted during their life course. On the other hand, this approach refers to the narrator's biography, to the ways in which, from the perspective of the present, the narrator selectively constructs their past (Rosenthal, 2004). At the same time, the biographical approach acknowledges both the role of the

interactional context in affecting the biographical material produced and the interpretive role of the researcher in shaping the analytical findings.

The adoption of a biographical paradigm allows a shift from examining the effects of single social factors on the emergence and/or course of psychosis to investigating the complex relationship between different social factors as well as their differential impact at various phases of a person's life course. Through a biographical narrative analysis, we expected to trace the ways in which specific combinations of social, familial and institutional factors shape distinct biographical trajectories and therapeutic itineraries, both before and after the emergence of psychosis.

Moreover, the biographical approach allows us to highlight the meaning making processes through which individuals with psychotic and psychiatric experiences make sense of their life course from the present perspective; we can thus examine how they draw actual life circumstances and events together in a biographical narrative, constructing a specific kind of self with respect to these experiences. The biographical approach allows an examination of the narrative and reflective aspects of the self. As such, it does not address pre-reflective aspects of the self, as depicted in phenomenological and dialogical approaches. In this study, we also draw upon Goffman's (1959a) dramaturgical analysis, in order to investigate the interactional processes through which participants performatively create particular kinds of ‘selves’ in the interest of presenting themselves as bearers of socially recognizable and acceptable identities.

2.2. Data collection

The study protocol was approved by the Ethics Committee of the Psychiatric Hospital of Thessaloniki and by the National Data Protection Agency.

27 biographical interviews were conducted with individuals with psychotic experiences. Participants had received one or more diagnoses of psychotic spectrum disorders, mainly schizophrenia, bipolar disorder and schizoaffective disorder, and were all in contact with mental health services. The age of emergence of psychosis for participants was 15–43 years ($M = 24.77$) and the time lapse from initial contact with mental health services to the interview ranged 2–31 years ($M = 11.00$).

Due to the focus of the study, we aimed to encompass a broad distribution of social factors regarding participants' socioeconomic position and therapeutic itineraries. To this purpose, eleven participants were recruited from acute wards of a state psychiatric hospital and their follow-up services, and fifteen from community mental health settings, including public community mental health services and self-help organizations. It was assumed that individuals recruited from private psychiatric clinics and psychiatrists in private practice would represent the more affluent sections of the population. However, despite concerted efforts, no access was granted for the former and only one participant was interviewed from the latter. Details of participants' demographic and socioeconomic characteristics can be found in Table 1.

Participants were recruited via the respective mental health services and organizations, which agreed to inform their members of the study. All individuals who fulfilled the inclusion criteria and volunteered to participate within the designated data collection period, November 2013 to May 2014, were included. The ethical protocol was followed both in the process of recruitment and during interviewing participants. During the preliminary meeting with one of the two authors, both of whom are trained psychologists, prospective participants were fully briefed, were provided with a study information sheet and signed a consent form. In that meeting, a baseline screening of prospective participants' suitability for participation was conducted, in order to ensure that their mental state was such that, firstly, they could provide informed consent, and secondly, participation in the study would not cause them significant distress. The baseline screening did not include

Table 1
Participant characteristics.

		Disowning psychotic experiences			Owning psychotic experiences		All participants Stigma
		Stigma	Chronicity	Marginalization	Suffering	Defiance	
Sex	M	3	3	2	2	4	14
	F	3	1	2	5	1	13
Age	20-29	2			1	1	4
	30-39	3			4	2	9
	40-49	1	4	2	2	2	12
	50-59			2			2
	Range	26-42	40-47	40-55	23-48	26-49	23-55
	Average	32.33	44.00	46.25	35.71	37.20	38.11
Class of origin	Working class	3	4	4	6	3	21
	Lower-middle class	3			1	2	6
Place of upbringing	Urban	3	2	2	5	3	16
	Rural	3	2	2	2	2	11
Educational level	Compulsory		2	2			4
	Secondary	2	1		2	1	6
	Further		1	1	3	1	6
Source of recruitment	Higher	4		1	2	3	11
	Acute wards	3	4	4			11
	Comm. m.h. services	2			3		5
	Self help	1			4	5	10
	Private psychiatrist						1
Age of onset	Range	20-30	23-29	Unknown	20-43	15-23	15-43
	Average	23.40	25.33	Unknown	28.43	19.00	24.57
Duration of untreated psychosis	Range	0-7	0-4	Unknown	0-2	0-5	0-7
	Average	2.00	1.33	Unknown	0.43	1.00	1.05
Time from onset to hospitalization	Range	0-5	0-4	Unknown	0-9	9-31	0-31
	Average	1.40	1.33	Unknown	3.25	18.20	4.06
	Participants hospitalized	5/6	4/4	4/4	4/7	5/5	22/27
Years of contact with m.h. services	Range	2-12	15-21	Unknown	3-12	9-31	2-31
	Average	6.00	18.67	Unknown	6.86	17.20	11.00

Note: The participant recruited through a private psychiatrist was not included in the trajectories.

formal assessment of type or severity of symptomatology. However, the requirement of informed consent effectively ruled out prospective participants at an acute phase, experiencing severe symptoms at the time of the study. In all cases one interview was conducted with each participant, by one of the two authors, in several locations in Greece. The interviews lasted from 30 to almost 120 min. Participants' mental and emotional state was monitored throughout the interview and the interview was adjusted accordingly.

As recommended for biographical interviews (Wengraf, 2001), participants were requested to recount their life in chronological order, from birth to the present time, and the interviewers were subsequently guiding the course of the narration with questions aiming to cover, in chronological order, important aspects of participants' lives. The interview schedule included questions on: family of origin; memories of early childhood; family, school, peer relations and activities during childhood; family, school, peer relations and activities in adolescence and early adulthood; emergence and early development of psychotic experiences; history of contact with mental health services and treatments; life conditions and events after the emergence of psychosis; familial circumstances, social and interpersonal relations, occupation and activities at present; future plans.

2.3. Data analysis

The data was subjected to biographical analysis (Chamberlayne et al., 2000) and specifically followed the analytical steps proposed by Rosenthal (2004). A table with participants' demographic and socioeconomic data was composed, including sex, age, social class, place of upbringing and level of education. Social class was determined by Olin Wright's taxonomy, adjusted to contemporary Greece (Zissi & Stalidis, 2017). Analytical tables schematically presented conditions and events of participants' life course, including adverse experiences with primary caregivers, adverse experiences in schooling, age of emergence of psychosis, first contact with mental

health services, diagnoses given, and types of treatment received. Chronologies were composed for each interview, containing a thematic summary of the participant's life course through each life stage.

Each interview was subjected to structural textual analysis, through line-by-line coding of thematic content and textual type, and detailed reflexive micro-analysis, tracing the development of the biographical narrative, following the principles of reconstruction and sequentiality (Rosenthal, 2004). This iterative process allowed the examination of the biographical importance of life events and conditions as well as the orientation of the narrator regarding their life. We thus moved from a depiction of the participants' objective life events and conditions to examining the way participants form their life story from the perspective of the present and constitute their self, both as narrators and in their narrated story. This led to hermeneutic reconstruction (Rosenthal, 2004; Schütze, 1999), whereby the central parameters of each biographical narrative were identified, and their dynamic relationship explored, culminating in textually and conceptually dense accounts of each biographical trajectory.

The last phase entailed the systematic comparison across biographical interviews, resulting in the formation of types and groups of dependent biographical trajectories. The analysis was conducted by both authors and consensual validation at all stages was the prerequisite for moving to the next stage, until completion.

Through the analysis, it became clear that the source of participant recruitment was an important differentiating factor between biographical trajectories, as it was linked to the type of contact with mental health services. For this reason, the single interview with a participant recruited from a private psychiatrist was fully analyzed but was not included in the typology construction phase.

3. Results

3.1. Types and groups of biographical trajectories of individuals experiencing psychosis

Using as the main analytical axis the biographical constitution of the self regarding psychotic and psychiatric experiences, the narratives elicited were organized into five biographical types, which are distinctive in terms of narrative form and style, depiction of life events and of experiences of distress, as well as therapeutic itineraries. These types were subsequently clustered in two groups of narratives. In a group of narratives, the narrators characteristically 'disowned' psychotic experiences; they systematically distanced themselves from their distressing experiences, using various strategies from concealment to repudiation, and seemed overwhelmed and subsumed by them. On the contrary, the narrators in the other group 'owned' their psychotic experiences; they recognized, described and attempted to make sense of their distressing experiences, appearing to assume agency over them. Participants placed in the second group appear to have built up a reasonably satisfying life with psychosis and are discussed elsewhere as examples of persons in recovery (Georgaca & Zissi, 2017, 2018).

Below, we present each biographical type in turn. The description of each type is accompanied by tables with representative extracts. The extracts selected are those that depict distinctive characteristics of each biographical type in relatively condensed form. The extracts are drawn from various interviews and the narrators are indicated by their initials.

The distribution of participants' demographic and socioeconomic characteristics for each biographical type and group is schematically presented in Table 1.

3.2. Biographical trajectories marked by stigma: the socially presentable self

The distinguishing feature of this biographical type is the struggle to portray a socially acceptable self through concealing experiences of distress and the distantiating of the self from the psychiatric label they entail; this strategy points to a central concern of narrators to manage social stigma. Participants included in this type tended to normalize life experiences in childhood and adolescence, presenting an idyllic past, which was disrupted by the sudden, unexpected and unexplainable appearance of psychotic experiences. The narrators stress the painful and uncontrollable character of their experiences and often quote their diagnosis. At the same time, they seem unwilling to describe and understand their psychotic experiences, but instead employ a range of strategies for avoiding, concealing and undermining them. In conjunction with this, they reject any possibility of making sense and managing these experiences psychotherapeutically, and instead they rely exclusively on medication.

The six biographical narratives included here were produced by three men and three women, aged 26–42 ($M = 32.33$), of working class and lower middle class background, with relatively high level of educational attainment, who were recruited from follow-up services of acute wards, community mental health settings and self-help organizations. Participants experienced distress in their 20s (20–30, $M = 23.40$) and came into contact with mental health services after the year 2001. By the time of the interview they had been in contact with mental health services for a period of 2–12 years ($M = 6.00$). The time from onset of psychosis to initial contact with mental health services ranged from 0 to 7 years ($M = 2.00$). In all cases initial contact with mental health services was delayed until reaching crisis point. Although some have been in contact with community mental health services, almost all participants followed the course of repeated involuntary hospitalizations in acute wards and being monitored by follow-up services of the wards between hospitalizations.

Participants appear to have been brought up in socially conservative, closed family environments, with limited opportunities for socialization, centered on extended family networks, concealment of

Table 2

Stigma – representative extracts.

Family
My parents did not tell me off as a child. I was a calm person, I was not getting into trouble ... At home the situation was calm, there were no tensions ... My parents, all these years, never argued between them, they get on well, there were no incidents at home ... My parents did not have friends, they were generally closed people, they did not bring friends at home. [TK]
Childhood / Adolescence
The primary school I was going to was a very good school, with good teachers, who loved the children. There was a basketball court and we were playing in teams. I was generally lazy, not very interested in school, I preferred playing. My mother pressurized me to an extent with homework, but by high school there was nothing she could do. [PA]
Psychotic experiences
And then all my phobias came out, all my insecurities, I was confused, I don't know how it happened, all this ... I was suffering, I kept seeing suspicion, everyone plotting against me, deaths wanting to take me on their side. Such things ... It was so hard, so hard, because I had all this psychological stuff. [VX]
Contact with mental health services
Now I take Invega, I have an Aloperidin injection every month, I take Titus, Akineton, and a sleeping pill, Circadin, so that I can sleep at night ... I was hospitalized in 2005, 2009 and 2010. In between I regularly see my psychiatrist at the psychiatric hospital. [PA]
Everyday life
Since I got ill, I have been closed, with the problem. I am calm, I have a relaxed life. I am trying to get over it, so that I can reopen my cycle, get back to normal rhythm. [ET]
Future plans
Once I get my degree I would like to work, in my specialization. I am not ready for a family yet, I don't think so. Maybe I could have a relationship, start a relationship and take it from there. [ND]

socially undesirable characteristics and drawing upon traditional systems of understanding the world and experience. From the onset of psychosis onwards, participants have further retracted in the restrictive but safe family environment, having minimal social contacts and relations. Their biographical plans include organized everyday life, work and an intimate relationship. For some, these prospects seem realizable due to increased access to educational and economic resources, while for others the gap between their biographical plans and reality seems insurmountable. Through support by the family of origin and systematic contact with mental health services, participants in this type seem to retain some contact with social reality and everyday functionality, albeit restricted and conditional upon availability of continuous support.

Concerning the constitution of the self with respect to psychotic and psychiatric experiences, the sense that comes across from these narratives is a concern to present a socially desirable, 'normal' self, who suffers from the invasion of strange and uncontrollable experiences, which do not belong to it; in other words, there is an attempt to construct a 'normal' self despite psychotic experiences. The struggle for normalizing one's self and life at the expense of concealment of any socially unacceptable and undesirable elements is at the center of these narratives, pointing to the possible effects of upbringing in socially conservative environments characterized by high levels of social control and stigmatization.

3.3. Biographical trajectories marked by chronicity: the self as 'mental patient'

The distinguishing characteristics of this biographical type are the identification of the narrators with the label of 'mental patient' and the resignation to a restricted life and lifelong pharmacological management of their condition, indicating that they are on a course of a 'mental patient career' (Goffman, 1959b). Narrators placed in this type also attempt to normalize their life prior to the onset of psychosis, which was disrupted by the intrusion of strange experiences. They describe their psychotic experiences in vague terms, stressing the intensity of

Table 3
Chronicity – representative extracts.

Family
I had a very good childhood. With my father and my brothers, we were very well. Very well, no problem. I just fell ill in '93. [XM]
Childhood / Adolescence
I went to a primary school in our neighborhood. It was great, with friends, everything was great. We all started as friends in primary school and continued together in high school. We played football, basketball, electronic games. Up to the end of high school, then we lost touch. [XM]
Psychotic experiences
Then I started drinking beers and my mind started turning around at the age of 20. My mind turned around. The alcohol hit me in the head. I started seeing strange things. My mind was all tangled up. I was 20 then, careless and immature. [BM]
Contact with mental health services
1993-2003 was a difficult decade, a very difficult decade. I was getting in and coming out of hospital frequently, getting in, coming out, for long periods. From 2003 until 2013, eleven years, I did not have a single hospitalization. I was coming every two months to get my medication and I was for ten years right, I worked, provided, traveled. And then I got ill again in 2013. [XT]
Everyday life
I now live with my mother, she has Alzheimer's and I look after her. I want to live a quiet life. The troubles I went through do not concern me any longer. We live on my mother's pension and a small pension I get. I do not get out of the house. I stay in, watch television and listen to the radio. [BM]
Future plans
I am ill, I am a patient. I take 5 pills and I must live with these pills. My life is my medication. I want to take my medication at the right time, the morning pills and the evening pills, eat, have an appropriate life routine, go for a walk, these are the normal things one must do. [XT]

suffering and lack of control over them, and offer their diagnosis as a label that denotes their experience. Participants talk about suffering from a mental disorder and identify themselves as a 'mental patient'. They have also accepted the chronicity of their situation, that they are bound to lead a restricted life, significantly reducing their biographical plans, receiving psychiatric care and monitoring their everyday life in order to retain a basic level of everyday functioning. Securing disability benefits on grounds of their psychiatric condition was the crucial turning point for all of them in terms of symbolically incorporating the role of 'chronic mental patient' as defining of the self.

Four narratives were included, of three men and one woman, aged 40–47 ($M = 44.00$), of working class background, with educational level ranging from compulsory to further education, all of whom were recruited from follow-up services of acute wards. Participants experienced the first breakdown in their 20s (23–29, $M = 25.33$), in the 1990s, and have 15–21 ($M = 18.67$) years of contact with mental health services. After an initial period of untreated psychosis (0–4 years, $M = 1.33$), they all came into first contact with mental health services through hospitalization. All of them experienced several involuntary hospitalizations, have been on heavy dosage of medication and exclusive contact with psychiatric hospital facilities. Like participants in the previous type, they initially delayed contact with mental health services, which for all of them led to compulsory hospitalization at entry point.

The strategies of attempting to normalize life prior to psychosis, disowning the psychotic experiences and leading a socially restricted life are shared with the previous biographical type. What distinguishes this type is that the narrators have given up any struggle to maintain a socially acceptable identity. They do not see their mental breakdown as a temporary state they are struggling to overcome and integrate themselves back to a 'normal' social life and identity. Instead they have fully succumbed to the identity of a 'chronic mental patient' and have resigned to a socially empty life prescribed for them. It could be argued that the narrators in this type, being older, with more years of psychotic experiences and contact with mental health services, presumably having had their biographical plans frustrated several times, have resigned to this role. Also, these participants had their first contact with mental health services in the 1990s, when community facilities were

Table 4
Marginalization – representative extracts.

Family
I am not one of those with hang-ups who say that their parents did this and that. What if they did whatever? My childhood years were fine. As long as my father lived, they were great. We were watching films, books, magazines, drawing ... There were tensions between my parents. They were incompatible. My father is like me, not like her. [FP]
Childhood / Adolescence
Primary school was fine. I did well, I had it with learning. In a village you hang out with the other kids. I had friends, who got married and disappeared. High school was strict, there was envy, the teachers could not help. I went for 3 years and then stopped. [EA]
Psychotic experiences
[Q: What do you think is happening with your mental state?] Nothing. I cannot know. I govern a body, a person. I am who I am. It is my character. I live like this. [Q: Are there thoughts or feelings that trouble you?] Apart from putting on nice clothes, doing my hair up and flirting, all this I miss. Up to now I get the package that I am not well. There reverse things you are talking about I do not have. I want to drink, to have fun, to go out. I have not done this in a month. [EA]
Contact with mental health services
[Q: Have you been hospitalized before in a psychiatric unit?] Yes, in Dr M's. I didn't know Dr M. I didn't know George. I honestly didn't know him. You know why? I didn't know him because I never engaged with medicine ... I have friendships in here, I do not have hospitalizations. I do not have enemies. The roads are open, everyone can go wherever they please, right? [KDJ]
Everyday life
I have some friends, but how many of them are alive? Most of them stuck to their families and drifted apart. The only ones I have left are on their own, in front of a tv. I do not have the television on, I do not even have it plugged in, my only reference is the radio. I cook pasta, rice, beans, I don't like meat much. I go to a place at the University campus and hang around. As soon as it gets dark, I go to bed. [MP]
Future plans
[Q: How would you like to see yourself in the future?] Like everyone, healthy, beautiful, rich [Q: How likely do you think this is to happen?] The possibilities? Very small, very small. Because it is not easy for people to accept that you went through a psychiatric, worked with a psychiatric for so many years, you are simply considered still ill. [EA]

not widely available and it could be argued that, in conjunction with their working-class background and low educational attainment, they followed the only route available to them, compulsory hospitalizations and exclusive contact with follow up facilities of the psychiatric hospital, resulting in a life course of chronicity.

3.4. Biographical trajectories marked by marginalization: the self as social outcast

The narratives included in this type are marked by a life course of social marginalization, coupled with narrative disorganization and rupture with common reality.

Four narratives were included, by two men and two women, aged 40–55 ($M = 46.25$), of working class background, with mixed educational attainment, all of whom were recruited from follow-up services of acute wards. In common with participants assigned to the previous two biographical types, these participants attempt to normalize life prior to psychosis, but a high degree of childhood adversity, including poverty, family disorganization and separation from parents, comes across through all these narratives. Due to the disorganization of these narratives, it is difficult to discern exact dates for life events and treatment experiences. Participants in this type seem to have had psychotic experiences quite early on in their lives, but have been in contact with mental health services after many years of distress and disorganization. Like narrators in the previous two types, they have experienced several involuntary hospitalizations and are in exclusive contact with psychiatric hospital facilities. They lead particularly restricted lives, with no family and social networks, completely dependent upon mental health and social welfare services.

These narrators do not recognize any experience of distress and do

not accept the identity of a person in distress or a 'mental patient'. In their attempt to construct a positive identity against the stigma of mental illness, they present a 'normal' self, that is faced with the attribution of a label that does not represent them. This repudiation of any experience of distress and the corresponding identity of a person in distress or 'mental patient' is accompanied by a marked lack of contact with common reality. This takes in most narratives the form of an organized delusional system regarding one's identity, in which often the self was presented as persecuted by hostile others, including mental health professionals. These were very disorganized narratives, which were very difficult to engage with in the interview. They were characterized by incoherence, idiosyncratic and vague references, and in some cases interpersonal tension and hostility.

These four narrators would clinically be recognized as the most disturbed patients, characterized by delusional organization, thought disorder, lack of insight and lack of contact with reality. From a biographical narrative perspective, they are examples of biographical trajectories of social outcasts, portraying a life cycle of extreme adversity, from childhood family disorganization to social marginalization and finally to dependence upon institutions and detachment from common reality.

3.5. Biographical trajectories marked by suffering: the self in distress

The central feature of this type of biographical narrative is the acknowledgment of distress and the active attempts to understand, manage and live with psychotic experiences in alliance with mental health professionals and services. Participants in this type produced rich biographical narratives, describing, evaluating and reflecting upon their life events and experiences, including their psychotic experiences. They described a reasonably normal childhood, without, however, glossing over various adverse experiences, such as family discord and victimization by peers. Most describe a particularly troubled adolescence, which set the scene for their subsequent mental health problems.

This type consists of seven narratives, by five women and two men, aged 23–48 ($M = 35.71$), mainly of working class background and urban upbringing, with high educational attainment, who were recruited from community mental health facilities and self-help organizations. Most participants experienced distress in their early 20s and some at much later age (20–43, $M = 28.43$), but they all had their first psychotic experiences after 2002. Their contact with mental health services took place 0–2 years ($M = 0.43$) later, and at the time of the interview their contact with mental health services ranged 3–12 years ($M = 6.86$). Apart from two participants, whose first contact with mental health services was through hospitalization, participants in this type sought help for their distressing experiences early on upon their emergence and dealt with them for years in community mental health settings. Three participants were never hospitalized, despite repeated psychotic crises, while others were hospitalized at times when the community management of their mental health was no longer possible.

Participants in this biographical type have always been part of social and professional worlds, having intimate relationships and friends, partaking in social networks, engaging in activities, some being in paid employment and raising families. They are engaged in a continuous attempt to make sense of their psychotic experiences as well as to manage them in collaboration with mental health services and professionals. They are all on psychiatric medication, but they have also engaged in psychological therapies, alternative therapies and self-help.

These participants appear to own their experiences of distress. They do not conceal, undermine or repudiate them, nor are they subsumed by them, like participants in the previous three types. They describe difficult and bizarre sensations, perceptions, urges, beliefs and emotions, which they have experienced and, to an extent, still experience. They acknowledge these as their own experiences, however strange and inexplicable they may seem to them. They also attempt to understand and manage them, assuming agency over them. These participants

Table 5
Distress – representative extracts.

Family
My grandparents looked after me, because my mother was a farmer she was always busy. Our home was small, but it was enough for us. It was warm, it was nice. I used to go and stay with my grandmother, my aunt, they also looked after me. We had a difficult time financially, my father had problems. I did not understand these things as a child, I just had a sense that we had difficulties. [GM]
Childhood / Adolescence
When I was 3, my mother left us both, me and my brother, to my grandparents' village. She lived in Thessaloniki, working. These were good years, with my grandmother and my grandfather. Later, when I was 10, she took us with her to Thessaloniki. We kept changing houses every few years. It was good at first, I was ok at school, I played basketball in a team. In high school I was very troublesome, I kept shouting at my mother, I had very few friends, I was getting into fights. [GK]
Psychotic experiences
I left my job, because I felt that a colleague was sending me abusive thoughts. I closed myself at home, and this was when the big trouble started. I thought that people put thoughts in my mind and that my thoughts were heard aloud. And then I was in bed for a year. I only got up to go to the toilet. I heard voices, in my head, continuously, the whole time. It was torture. I could not get washed, I did not have a shower for almost a year, because I felt they could see me, and I was ashamed. [XY]
Contact with mental health services
I kept my job for six months, while having this paranoia. I was seeing a doctor every week, so that I could keep my job. Three years went like that When my paranoia got bad again, I changed doctor. I heard there was a good doctor at the Mental Health Centre. She increased my medication to 40 mg Zyprexa per day, a rather large dosage. I put on an awful lot of weight. She wanted to see me every two weeks, because she saw I was in a bad state. But I had not gone into hospital by that point. [EB]
Everyday life
After my first crisis I decided to do things for me, because before I was dedicated to my children, to my home, to my work. So, I went and trained in diving, and we are a really nice team. We have an association, we do sea bed cleansing once a year, we meet regularly. I am generally seeking things that will make me happy, because if I am happy, so is my family. [IA]
Future plans
I would like to find a job soon, so that my son can resume his studies. As for me, I do not know what will happen, what I can expect, I have no plan, apart from work. I would like to have a partner, but I do not know to what extent this is possible, with two children depending on me. I am also a candidate for a council seat in the local elections. [IA]

construct thus a self who struggles with bizarre, painful and uncontrollable experiences. Moreover, they have managed to maintain an active personal, interpersonal and social life despite, or rather with, ongoing and recurring mental health problems. They come across as suffering subjects engaged in a continuous struggle of self-definition and self-management in the face of severe distress, in line with notions of clinical and personal recovery (Davidson & Roe, 2007).

3.6. Biographical trajectories marked by defiance: the self as survivor

The distinguishing feature of these biographical trajectories is the presentation of the self and the definition of distressing experiences in opposition to the biomedical model of mental illness and psychiatric practices. Participants in this type also acknowledge and describe their experience of mental distress. However, the emphasis in these narratives is less on making sense of distressing experiences through linking them with one's life course, and more on challenging the dominant understandings and practices regarding their distress that were imposed on them. Descriptions of the ineffectiveness and violence of treatment within the mental health system abound in these narratives and are much more developed than accounts of distressing experiences. These participants, unlike those of the previous type, depict a process of recovery not from mental distress but from the mental health care system. They own their experiences of distress, which they redefine in psychosocial terms, and orient towards recuperating a normal identity from the imposition of the label of 'mental patient'. In this sense, they

Table 6
Defiance – representative extracts.

Family
<p>I do not have good memories from my childhood. I remember my mother and my father arguing. Generally, the family atmosphere was not very calm. If, however, I was to define a start, upon which my psychiatric future was founded, this would be, I think, the death of my father when I was about 10. ... After my father's death, my mother's life was very unstable. She had affairs and was bringing in people who were doing drugs. She was not a user herself, she was mainly drinking and getting drunk. All in all, there was never the calmness and safety that a child should feel at home. [GI]</p>
<p>Childhood / Adolescence</p> <p>We kept moving houses and so I changed many schools. No sooner would I make friends, and we would move again. At school there was a lot of violence, because I was born outside marriage, I do not know how they always found that out, I was never wearing skirts, and especially by the female teachers I was treated as the out-of-wedlock, non-baptized tomboy, and then the kids would start. I remember a lot of violence from the kids. In high school things got worse, because I had gaps from primary school, my mother refused to get me support, so I failed the year. At 15 I left home and school and lived in squats for a few years. [LK]</p>
<p>Psychotic experiences</p> <p>When the voices started, because they felt so real, I thought that a group of people suddenly started talking about me. This was intensified by the fact that I would come out in the balcony and see closed shutters, and I thought that they are talking behind the shutters. Because I also had visual hallucinations, that is to say, I had seen the voices, this feeling and belief were very strong. I started believing that the friends of an ex-girlfriend, who dumped me, were mocking me. [DX]</p>
<p>Contact with mental health services</p> <p>I had psychotherapy a couple of times over the years. In 2012, before I was hospitalized, my mother took me to various professionals, mainly psychiatrists, whom I did not like. And then I found Dr L, who works in the Mental Health Centre. She saw me a couple of times and that really helped me. Now I go whenever I want and I see her at the Mental Health Centre ... When I was hospitalized, Dr L came and spoke with my psychiatrist and instead of 20 mg or more that he was planning on giving me he gave me 15 mg, so that I could reduce it faster. [DZ]</p>
<p>Everyday life</p> <p>I stopped using substances for three months now. I do not think too much. I am well. I play music. I write songs. I have friends. I go out very often. I am in a good mood. I flirt. It is all part of life. I feel much stronger after what I have been through, especially the second hospitalization. [DZ]</p>
<p>Future plans</p> <p>I am generally over-optimistic, so I try to see what is practically possible. I am thinking of starting a social work degree. I am preparing a puppet show performance, but I am not sure whether I will manage it, because my arms and legs are not working very well after the stroke. In any case, I need to solve my financial problem. I do not know whether it will be solved by any of the two, but it must be solved. [LK]</p>

are positioned, some explicitly so, as 'survivors', in line with the international mental health survivor movement (Campbell, 2013).

This biographical type contains five narratives, of four men and one woman, aged 26–49 ($M = 37.20$), split between working class and lower middle-class background, with high educational attainment, all of whom were recruited from self-help organizations.

All participants describe various adverse childhood experiences, in the family and the school environments, and a particularly troubled adolescence. They all locate the emergence of severe distress in late adolescence or young adulthood (15–23, $M = 19.00$). They sought contact with mental health services 0–7 years later ($M = 1.05$) and at the time of the study they had been in contact with mental health services for 2–31 years ($M = 11.00$). Apart from one participant, for whom hospitalization was the point of contact with mental health services, participants managed their distress for many years through medication in community settings (9–31, $M = 18.20$), and were all hospitalized at later times, when community management was no longer sufficient. Most participants sought from early on alternative mental health professionals and coping strategies. This seems to have been made possible by their increased access to educational resources, their broader politicized and critical orientation and the social support they received by family and friends in seeking alternatives.

The quest for alternative modes of dealing with severe distress eventually brought them into contact with self-help organizations, of which they have been active members to date. Participation in self-help organizations provides participants with alternative modes of understanding and managing their mental distress. It also constitutes a social space for building social support networks, friendships and an organized everyday life. Finally, it enables the re-orientation of identity construction to the socially recognizable and valued identity of 'survivor' of distress and psychiatry. Participants in this type continue experiencing severe mental distress, they are all on medication and are in systematic contact with mental health services. However, unlike narrators of the previous type, who build alliances with the mental health service system based on trust, participants self-defined as survivors perceive contact with mental health professionals and services as tactical, driven by a need for medication supply, social welfare support and avoidance of hospitalization. At the same time, they manage their life and mental health through employing alternative modes of understanding and dealing with their distress, as well as building social support networks through active engagement in self-help collectivities. The characteristics of this trajectory are in line with other studies of persons involved in the psychiatric survivor movement (Adame & Knudson, 2007; Crossley, 1999).

4. Discussion

4.1. Social factors affecting biographical trajectories in psychosis

While clearly distinguishable types of biographical trajectories are discernible from the narratives elicited, these trajectories do not seem to be differentiated between them in terms of any single demographic and socioeconomic indicator. Neither were particular trajectories related to type, severity and course of psychotic symptomatology, or to specific diagnostic categories. The above indicates that these biographical trajectories are shaped by a conglomeration of clinical and social factors, which dynamically interact.

The most noteworthy demographic and socioeconomic characteristic of the sample is the lack of middle and upper class participants; this can be attributed partly to the higher percentages of psychotic disorders found in the lower socioeconomic spectrum (Morgan et al., 2008) and partly to restrictions in sampling. It is also worth noting the relatively high level of education across the sample, which can be explained by the expansion of access to further and higher education in Greece to the working class population from the 1980s.

A distinguishable trend can be discerned in the two types of trajectories marked by chronicity and marginalization, which were elicited from participants of older age and working-class background, who were exclusively recruited from psychiatric hospital facilities. These participants produced the poorest and most disorganized narratives. They live socially isolated and dependent lives, following typical careers of 'mental patients' (Goffman, 1959b), with no biographical plans or prospects. They first experienced severe distress in the 1990s, a time when community mental health services were not widely available. We may assume that this, in combination with their socioeconomic origin and low level of education, contributed to their therapeutic itinerary of successive compulsory hospitalizations with exclusive contact with psychiatric hospital facilities and life-long dependence on the mental health and social welfare system. Participants clustered in the other three types of biographical trajectories share commonalities in terms of sex, age, socioeconomic position, place of upbringing and level of education, which indicates that other combinations of factors, possibly related to implicit transmitting mechanisms of socialization, may be related to their particular trajectory.

In all narratives, the emergence of psychotic experiences is presented as a point of biographical disruption, producing discontinuity and necessitating adjustments, a common theme in narratives of the experience of psychosis (Boydell, Stasiulis, Volpe, & Gladstone, 2010;

Barrier, Khan, Cater, & Picken, 2007). Most participants, across biographical types, attempt to normalize the period of childhood and adolescence as a way of stressing the discrepancy of life before and after the emergence of psychosis, through concealing or undermining adverse conditions and events. However, various adverse childhood experiences, mentioned in the literature (Bentall et al., 2014; van Winkel et al., 2013), could be discerned from participants' accounts. This was more so from those marked by suffering and defiance, who were more forthcoming, and those marked by marginalization, who appear to have experienced significant childhood adversity. The childhood adversities recounted include troubled relations with primary caregivers, for example parental absence or neglect and discontinuity of care, adverse situations in the family of origin, such as parental conflicts and poverty, difficult schooling experiences, such as social withdrawal, victimization or behavioral problems, and troubled adolescence, characterized by conflicts with parents, behavioral problems, emotional instability, increased social isolation and substance abuse.

Most participants locate the emergence of psychotic experiences in their 20s, a common age for the emergence of psychosis. However, two participants first experienced psychotic symptoms in their 40s and three in adolescence. Participants located in the biographical types marked by stigma, chronicity and marginalization describe a long period of experiencing distress before coming into contact with mental health services. The pattern described in most cases is avoidance until distress reaches crisis point, followed by hospitalization, in most cases involuntary, as the point of entry in the mental health service system. Participants located in the biographical types marked by suffering and defiance, on the other hand, dealt with their distressing experiences for several years through contact with community based mental health services and professionals, even during periods of severe breakdown, apart from two cases, who were very quickly hospitalized amidst a psychotic crisis. Thus, the period of time from emergence of symptoms to seeking treatment, in conjunction with the type of treatment sought, seem to distinguish the different types of biographical trajectories and to be related to the differing therapeutic regimes they follow. These findings concur with the importance of early identification and treatment of psychosis (Hansen, Stige, Davidson, Moltu, & Veseth, 2017; Marshall & Rathbone, 2011), adding the proviso of the importance of community management and avoidance of hospitalization for a favorable course. We also assume that ignoring and concealing emerging experiences of psychosis due to stigma is what renders coercive measures, such as involuntary hospitalization, almost inevitable. This highlights the detrimental effects of stigma in initiating a therapeutic itinerary of repeated hospitalizations, exclusive contact with psychiatric facilities and chronicity.

Another factor that seems to differentiate the biographical trajectories discerned, and in particular the therapeutic itineraries followed by participants, is the type of mental health services available. Given that in Greece the shift from asylum psychiatry to community mental health care started in the late 1980s and community mental health care was not commonly available until the late 1990s (Christodoulou, Ploumpidis, Christodoulou, & Anagnostopoulos, 2012), participants who first developed psychosis in the 1990s and before had recourse only to psychiatric hospital facilities. This can be clearly seen in participants clustered in the biographical types marked by chronicity and marginalization, discussed above, who then continued exclusive contact with psychiatric hospital facilities to date. On the other hand, individuals experiencing severe distress from the late 1990s onwards, as is the case with most participants in the other three types, would have recourse to community mental health treatment. Indeed, many of the participants clustered in the biographical type marked by stigma and all in the biographical types marked by suffering and defiance have had systematic contact and received treatment in community settings, some having avoided hospitalization altogether. Availability of community mental health care seems to have been important for the therapeutic itineraries and life course followed by participants clustered in the two

biographical types marked by suffering and defiance. On the contrary, participants in the biographical type marked by stigma, despite having been in contact with community mental health services, have fluctuated towards use of psychiatric hospital services, and are at risk of entering a chronic psychiatric career. This leads us to conclude that availability of community mental health services, however important it may be, cannot by itself guarantee favorable course and successful management of psychotic symptoms.

The shift in professional discourses and practices effected by the development of community mental health systems, in conjunction with anti-stigma campaigns and increased visibility of mental illness in the media, enabled the dissemination of more progressive modes of understanding and managing distress in the public realm; this has lessened the stigma of mental illness (Pescosolido, 2013). It is notable that participants presenting themselves as in distress and as survivors openly acknowledge their mental distress to their social circles and adopt biopsychosocial explanations of it; more importantly, they actively seek to understand and manage their psychotic experiences in collaboration with mental health services and professionals or in self-help communities. Again, this shift in popular and professional discourses does not seem to have been picked up by participants clustered in the biographical trajectory marked by stigma. We may assume that this is due to the socially conservative environment of their upbringing. The belated development of the self-help movement in Greece in the last two decades (Fafalios & Georgaca, 2008) has provided further opportunities for individuals seeking alternatives to adopt critical psychosocial understandings of their psychotic experiences, to join self-help groups and to develop alternative strategies for managing their distress.

Another factor that seemed to distinguish the different biographical types concerned the existence of interpersonal relationships and social networks, both prior to and after the emergence of psychotic experiences. Participants in the biographical types marked by stigma, chronicity and marginalization seem to have always lived in a restricted and restrictive familial environment with limited social contact and social engagement. These individuals retracted even further in the protective environment of their family after the emergence of severe distress, having few, if any, interpersonal relationships and almost no engagement in social life. This can be interpreted as 'positive withdrawal', a strategy of managing distress through keeping distance from the social environment (Corin & Lauzon, 1992). The long-term effect of this, however, for these participants is social isolation and marginalization. On the contrary, participants who come across as persons in distress and as survivors seem to have always been part of familiar, friendship and social networks, to have engaged in activities and to have had close interpersonal relationships, which they retain to the present. This finding concurs with the emphasis on the role of attachment to primary caregivers, adversities in the family environment and dysfunctional family communication both in the development and in the course of psychosis (de Sousa, Varese, Sellwood, & Bentall, 2013; Gumley, Taylor, Schwannauer, & MacBeth, 2014; Tait, Birchwood, & Trower, 2004), and is in line with the increasing acknowledgment of the importance of social and interpersonal networks and social support in the management of severe distress (Anderson, Laxham, & Priebe, 2015; Bebbington, 2013). The parameter, however, that seems crucial in our material is the extent to which participants were raised in a socially conservative and closed family system, which restricted opportunities for partaking in interpersonal and social networks and more progressive ways of understanding and managing severe distress, or in a more progressive and open family system, which allowed them access to broader social networks, practices and modes of sense making. This is particularly pertinent for Greece, where the family continues to play a crucial role in the survival and well-being of its members, particularly when these members are faced with distress and disability (Koutra et al., 2016).

4.2. Limitations

The small number of participants, however adequate it might be for qualitative studies, does not allow generalization. Generalizability is also limited by the limitations in sampling in terms of participants' socioeconomic background as well as by the particularities of the sociocultural context, in which the study was conducted. The broad range of participants' age and years of contact with mental health services, as well as of diagnoses and types of psychotic experiences, can be considered a disadvantage. It was, however, a deliberate choice in the study design to recruit participants from different sources in order to encompass the range of individuals with psychotic experiences.

The method used for the collection of the material, a single biographical interview with a researcher who was a trained psychologist, will have certainly affected the amount and type of information elicited. It can be assumed that individuals in severe distress with long-term experience of contact with mental health services would shape their narrative accordingly, when talking to yet another mental health professional. Also, the lack of therapeutic relationship would have limited the range of experiences that the participants might be willing to share. This might explain, to some extent, the unwillingness of some participants to acknowledge and describe their psychotic experiences.

Finally, it is acknowledged that the narrative biographical paradigm used, as well as the retrospective character of the narratives elicited, cannot lead to claims regarding causal relations between socioeconomic factors and biographical routes of individuals experiencing psychosis.

4.3. Conclusions

This study attempted to enrich the flourishing literature on the course of psychosis and on recovery, by tracing biographical trajectories of individuals with psychosis and outlining their main characteristics. The different biographical trajectories traced in this study indicate that there are different paths of recovery, not all of which are equally successful in achieving a satisfying life with psychosis. Some trajectories enable a worthwhile and meaningful life and can be said to facilitate recovery. Others lead to a life of chronicity and social isolation, in a direction opposite from recovery. The study has identified various social factors that are linked to differentiated paths of recovery, including early life experiences, recognition and dealing with psychotic experiences, contact with mental health services and social engagement. This, we think, is its main contribution.

Through adopting a biographical perspective, we were able to delineate distinctive biographical types. Through their systematic comparison we arrived at a complex picture of a dynamic interaction of factors related to the broader sociocultural context, the mental health service system and the individual's network of familial and social relationships. It seems that, instead of investigating causal mechanisms leading from single social factors to mental distress, a more fruitful research approach would be to examine the complex interaction of familial, social and institutional practices and discourses which shape biographical trajectories of individuals, whose life has been marked by experiences of psychosis. This is in line with the biopsychosocial model and the tendency to build interactional models of mental distress.

4.4. Clinical implications

Prevention interventions can be enriched by taking into account the complex interrelation of factors that shape the onset and course of psychosis. The existence of psychosocial hardship in childhood and adolescence, that is traced in all narratives, in combination, in some cases, with low socioeconomic background and low level of education, points to the need for primary prevention strategies that address different aspects of adversity in the general population, with particular emphasis on the most vulnerable groups. At the level of secondary prevention, the importance of early recognition and management of

psychosis points to the need for accessible mental health services, that are attentive to early signs of distress. Community management of severe distress, both upon onset and long-term, seems to distinguish the more recovery-oriented biographical trajectories, as opposed to the hospital-based psychiatric facilities, that are the exclusive point of reference for persons in biographical trajectories characterized by chronicity. This renders the availability of community-based services and progressive mental health practices and discourses a priority in the organization of mental health service provision.

The existence of supportive familial, interpersonal and social networks seems to be a central element of the recovery-oriented biographical trajectories, highlighting the centrality of social support and social networks both for maintaining mental health and for recovering from severe distress. This points to the need for primary, secondary and tertiary prevention strategies that foster social participation, interpersonal relations and social networks, in order to combat social isolation and achieve continuing social integration.

Finally, stigma comes across in this study as a factor that weaves through the family environment, social relations and mental health services, affecting the person's self, relations and everyday life with detrimental consequences. For this reason, we think that anti-stigma initiatives, at all levels mentioned above, is a precondition of any attempt to support recovery for individuals with psychotic experiences.

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None.

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