‘Snitches get stitches’: A qualitative exploration of childhood bullying amongst individuals with early psychosis experiences

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Abstract

Background

There is a strong argument throughout the literature that childhood trauma and adverse experiences should be considered when working with individuals who experience psychosis. There has been a developing interest in the relationship between childhood bullying and psychosis, although to date, there is limited research in this area. Bullying is a pertinent issue for young people, which argues for further consideration in Early Intervention for Psychosis (EIP) settings.

Aims

The aim of this research is to explore the subjective experiences of childhood bullying for individuals who access EIP services. A secondary aim is to explore whether individuals perceive bullying to be relevant to their experiences of psychosis.

Methodology

Semi-structured interviews were conducted with eight individuals. Interviews were analysed using Interpretative Phenomenological Analysis

Results

Four superordinate and accompanying subordinate themes emerged. The superordinate themes were 'facing daily threat', 'overcoming systemic mistrust', 'negotiating power imbalance' and 'a process of evolving identity'.

'Facing daily threat' conveyed how participants experienced bullying as traumatic. Bullying experiences were considered highly relevant to current experiences of paranoia. 'Overcoming systemic mistrust' reflected neglectful responses from teachers and the ways participants felt unheard when first engaging with services. 'Negotiating power imbalance'

reflected both the complex power relationships within school and the influence of wider social power. ‘A process of evolving identity’ explores the gradual shifts in how participants viewed themselves after verbal bullying. Participants’ psychosis experiences included hearing critical, attacking voices, reinforcing the same messages received from bullies in school.

Discussion

The results are clinically important as they contribute to understanding experiences of psychosis in the context of bullying history. They also highlight the wish for individuals to have more opportunities to discuss bullying in EIP services. Finally, they argue for school systems to further consider their responses to children who seek help for bullying.

CHAPTER ONE: INTRODUCTION

Chapter overview

To introduce the aims of the study and offer context for the research, Part I of this chapter describes a broad overview of psychosis including historical conceptualisation, definitional concepts, service context and discussions around aetiology. Through this, trauma and adverse childhood experiences are highlighted as an important factor in the field of psychosis, but childhood bullying is seen to be comparatively less present in the literature. Part II therefore explores the concept of bullying. It is defined and discussed including relevant theoretical context and empirical literature exploring its potential association with psychosis. Part III is a systematic literature review exploring the relationships between childhood bullying and psychosis. Part IV provides rationale for the current study, along with aims and research questions.

Part I: Exploring Psychosis

Historical context of psychosis

There is a long history of what we now refer to as ‘psychosis’. In 1841, the German physician Karl Canstatt introduced psychosis into the psychiatric literature. It was an abbreviation of ‘psychic neurosis’, a disorder of the mind (as opposed to ‘neurosis’, a disorder of the nervous system). Seen as a psychic manifestation of brain disease, it became the equivalent of older notions of madness and insanity (Burgy, 2008).

In the late 19th century, Emil Kraepelin offered the term ‘dementia praecox (early)’ to describe a decay in mental efficiency (Kraepelin, 1893). It was thought to be a neurodegenerative disorder from which there was little or no hope of recovery. Later, Eugen Bleuler revised ‘dementia praecox’, suggesting ‘schizophrenia’ instead which means ‘splitting’ (schizen) of ‘the mind’ (phren) (Ashok, Baugh, & Yeragani, 2012). He

considered schizophrenia as a group of diseases, categorised into subgroups (e.g. paranoid schizophrenia). He also proposed that symptoms could be grouped into ‘positive’ and ‘negative’ subcategories; these remain central to the current definitions and diagnostic constructs which will now be outlined.

Defining psychosis

A formal definition offered by Bentall (2003) is that psychosis refers to ‘severe psychiatric disorders in which the individual is out of touch with reality’. Psychosis might include hearing, seeing or feeling things that other people do not (known as ‘auditory, visual or tactile hallucinations’) or holding beliefs that are not usually shared by others (‘delusions’). When people have these experiences, they might appear distracted, talk back to voices or talk in quick succession, in a way that other people might find hard to follow (‘disorganised speech’ or ‘thought disordered’) (British Psychological Society (BPS), 2017). These experiences are known as ‘positive symptoms’ of psychosis as they represent changes that are additional to usual experience. Positive symptoms are often defining features of psychosis.

On the other hand, ‘negative symptoms’, such as lower motivation, refer to a change in someone’s ability to function as they previously had (National Institute for Health and Care Excellence (NICE), 2015). However, negative experiences may arise from feeling overwhelmed by the more unusual experiences, or side effects of medication (BPS, 2017).

Diagnostic terminology

The Diagnostic and Statistical Manual of Mental Disorders (DSM-V) combines psychoses into one chapter (American Psychiatric Association (APA), 2013); psychosis can therefore be viewed as an umbrella term that includes the experiences described above.

The most common diagnostic term under this umbrella is schizophrenia. The DSM-V (2013) diagnostic criterion for schizophrenia is that the person experiences two or more psychosis characteristics (e.g. delusions, hallucinations) for at least a month (with overall disturbance lasting over six months). Work, interpersonal or personal care also need to be markedly reduced since symptoms started. The criterion also requires other attributes (e.g. substance misuse, medical conditions) and other disorders (e.g. bipolar, schizoaffective disorder) to be ruled out (APA, 2013).

Clarity is required regarding the use of the terms 'psychosis' and 'schizophrenia' throughout this research. The focus of the study is on those experiencing psychosis, therefore using the broader umbrella term and paying less attention to diagnostic categories. However, as much of the historical research refers to 'schizophrenia', it may be that this term is used when describing prior research.

Critique of psychosis terminology

Psychosis terminology is not always considered helpful. It is argued that conceptualising unusual experiences as pathological characteristics of mental illness is stigmatising and fails to reflect human experience (BPS, 2017). Some groups, such as The Hearing Voices Movement, offer alternative terms like 'voices' instead of 'auditory hallucination'. They describe voices as 'meaningful and understandable' as opposed to a mental illness (Escher & Romme, 2012). Whilst it would be preferable to be able to use terminology advocated by this movement throughout, the clinical and research literature is dominated by diagnostic terminology. Therefore, in providing background to this research, it is not possible.

Prevalence and demographic features

A recent systematic review found that globally, approximately one in 150 individuals will be diagnosed with a psychotic disorder across their lifetime (Moreno-Küstner, Martín & Pastor, 2018). In the UK it is estimated that 1% of the population will experience psychosis (NICE, 2014). The rate of schizophrenia has been found to vary with ethnicity (Fearon et al., 2006), with the highest incidence rates amongst Black Caribbean and Black African groups (Kirkbride et al., 2008). However, this figure is thought to miss the institutional racism found in health services where Black Caribbean and African groups are more likely to be diagnosed (Singh & Burns, 2006).

It is rare for psychosis to be experienced by children under the age of 14 and there is a marked increase in prevalence between 15-17 years old (Thomsen, 1996). Schizophrenia spectrum diagnoses are usually identified in the 15-35 age group (Kessler et al., 2007). It is also reported that 75% of men and 66% of women have their first episode by 35 years old (Kirkbride et al, 2006). However, as MGrath et al. (2016) noted, although most first psychosis experiences occur in adolescence, estimates indicate nearly a quarter of first onsets occur after age 40, so it is not a period to be ignored. Females have been found to be 1.63 times older than males when they first experience symptoms (Eranti, MacCabe, Bundy, & Murray, 2013). Also, a higher prevalence is reported in men (Aleman, Kahn & Selten, 2003). However, this is widely disputed with many arguing there is insufficient evidence (Perala et al., 2007)

The psychosis continuum: from 'normal' to 'abnormal'

It is argued that there is no clear division between 'mental health and mental illness' (or normality and abnormality) (Cooke & Kinderman, 2018). Instead, it is proposed that a continuum exists between good and poor mental health, and we are all likely to move along

this throughout our lives (Verdoux & Van Os, 2002). It is further argued that some of the more unusual phenomenon associated with psychosis, such as hearing voices, exist in the normal population and may only come to the attention of services if they cause distress or concern (Cooke & Kenderma, 2018).

Furthermore, Bentall (2003) argues that hearing voices, suspiciousness and paranoia are all experiences that form complex personal characteristics and traits. This argument is supported by Beavan, Read, & Cartwright (2011) who stated that 'many people have heard voices at some point in their life', and Bebbington et al., (2013) who proposed that paranoia is 'so common as to be almost normal'.

David (2010) argues that the evidence for the continuum view can be challenged on methodological and conceptual grounds. He suggested identifying distinctive psychotic phenomena in clinical disorders, but still considering the origin of this phenomena as a 'normal' cognitive process.

Early psychosis experiences

Criterion has developed to assist in identifying those who may be in the earliest phase of psychosis, known as the prodrome phase. These aim to identify those at risk of developing psychosis. These are referred to as 'At Risk Mental State (ARMS)', 'Ultra High Risk (UHR)', Clinical High Risk (CHR) or 'prodromal criteria' (Broome et al., 2005; Miller et al., 2003; Nelson, Yuen, & Yung et al., 2011; Yung & McGorry, 1996). They are often used interchangeably and are broadly defined by either transient (brief and limited) psychotic symptoms or 'subclinical' positive symptoms (e.g. hallucinations). To be identified as at risk, individuals also usually have lower day-to-day functioning and a family history of psychosis.

Various longitudinal studies have considered whether these criteria can truly predict psychosis (Cannon et al., 2008; Yung et al., 2003). In a review, Olsen and Rosenbaum (2006) found between 10-50 % of UHR patients transitioned to psychosis. However, Van Os and Guloksuz (2017) argued the samples are individuals with minimal psychosis experiences and predominantly other mental health difficulties (e.g. anxiety, depression). Furthermore, a meta-analysis concluded that less than 1% of those with subclinical psychotic symptoms transition to psychosis (Kaymaz et al., 2012). Therefore, evidence is clearly in debate.

The term First-Episode Psychosis (FEP) is used to describe when an individual first contacts services or has their first inpatient admission for psychosis symptoms (Menezes, Arenovich & Zipursky, 2006). However, operationally the term has adopted various definitions. Some services add constraints to include duration of antipsychotic use or duration of psychosis (Breitborde, Srihari & Woods, 2009). Therefore, using the term FEP can be misleading in clinical and research settings and make it difficult to draw comparisons.

Early Intervention for Psychosis (EIP)

Consistent argument developed for intense early intervention because of this interest in ‘at risk’ groups and a late adolescence-early adulthood onset (Birchwood et al., 1997). Supporting this view, delay in first treatment was considered a ‘major problem’ (Yung & McGorry, 1996). Many remain convinced that early intervention may help to reduce poor outcomes, transition to psychosis (Berry et al., 2013; Bendall et al., 2013, Fusar-Poli et al., 2012; Norman & Malla, 2001) and reduce inpatient admissions or crises (Fusar-Poli et al., 2012)

Considering this rationale, the Department of Health (DOH) issued plans to establish specialist teams to offer early intervention for individuals experiencing a FEP (Department of Health, 2001). These were named ‘Early Intervention for Psychosis’ (EIP) services. Commissioning was originally for 14-35 year olds but is now ageless. This was to address the previous neglect of those experiencing psychosis later in life. In a changing political climate, EIP services have moved back and forth between heavily resourced independent teams to being integrated within mainstream mental-health services.

In 2016, the NHS issued a paper ‘Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance’ (NHS England, 2016). It sets the expectation that within 2 weeks of referral, more than 50% of people experiencing FEP will be treated with a NICE approved package. This includes offering Cognitive Behavioural Therapy for Psychosis (CBT-P), family intervention, employment or education support and physical health checks (NICE, 2015).

Controlled and quasi-experimental research has found that individuals who engage with EIP services show improved psychotic symptoms and fewer relapses, reduced substance misuse and high patient satisfaction (Petersen et al., 2005, Alvarez-Jiménez et al., 2011). However, EIP services have been heavily criticised for moving experienced staff and resources from generic services (see Pelosi & Birchwood, 2003). Verdoux et al. (2001) also raised ethical issue with inappropriate treatment (including powerful anti-psychotic medication) being offered to those who might never fully develop psychotic disorders. Therefore, in addition to definition and diagnostic disputes, treatment pathways are disputed in the field of psychosis.

Development of psychosis

The debate continues through various professional and theoretical positions seeking to explain the aetiology of psychosis. As Geekie (2013) stated, "we could view our search of the holy grail of schizophrenia in broader terms as reflecting the efforts of our culture to come to grips with madness". Traditionally the focus of this debate was on genetics and biology, with later thought developing around cognitive, psychosocial or systemic processes.

The medical perspective

There has been a consensus in psychiatry of a hereditary link in psychosis (Gottesman, 1991). Evidence for this view comes from family, twin and adoption studies (e.g. Gilmore, 2010; Stefansson et al., 2009; Sullivan, Kendler & Neale, 2003). However, as Plomin et al. (2008) states "many behaviours run in families, but family resemblance can be due to either nature or nurture" (p.70).

Meta-analyses have argued that there are significant differences between various brain structures of those with and without schizophrenia (Van Erp et al., 2015; Ven Erp et al., 2018). However, as the construct of schizophrenia varies, individuals across brain studies may vary significantly. They may also have taken medication over a long period which could have explained changes to brain structures (Moncrieff & Leo, 2010)

The 'dopamine hypothesis' also became a lead medical theory. This proposes over-activity in the dopamine system, leading to unusual experiences (Kapur & Mamo, 2003). It is mainly supported by evidence of drug effects (i.e. amphetamines increase dopamine and produce psychosis-like experiences and neuroleptics block dopamine receptors and reduce psychotic experiences) (Howes & Kapur, 2009).

The strongest critique of the medical model is the wide scale neglect of a person's life experience. As Read, Magliano & Bevan (2013) state, "it is as if psychiatric brain researchers fail to grasp what the brain is for" (p.64). An ideology that minimizes psycho-social causes is also noted to be highly beneficial for the enthusiastically supportive pharmaceutical industry (Mosher, Gosden, & Beder, 2004; Read & Dillon, 2013). These criticisms lead to exploration of other sides of the debate.

Firstly, systemic and attachment perspectives will be presented. This will be followed by views around adversity and trauma, and lastly conclude with cognitive conceptualisations.

Systemic perspective

The family environment has been found to play a key role in the development of psychosis (Tienari et al., 2004; Kavanagh., 1992; Pitschel-Walz et al., 2001), with negative family environments being linked to poorer overall prognosis (Geller et al.,2000). Bateson et al. (1956) proposed a 'double bind theory' based on communication and pressures between two or more people in a system, such as family. Children who frequently received contradictory messages from parental figures (such as being critical but caring, expressing love but showing anger) were thought to be more likely to develop schizophrenia. It was argued that prolonged exposure to inconsistencies prevented coherent internal realities being constructed, thus manifesting as psychosis experiences (Bateson et al., 1956).

Brown et al. (1958) suggested the importance of expressed emotion (EE) in families in the maintenance of schizophrenia. EE is a communication style of highly expressed emotions, over-involvement, criticism or hostility. Patient relapse was more likely if returning to a family with high EE (Brown et al., 1958). However, mechanisms of this relationship are not well understood (Barrowclough & Hooley, 2003)

Attachment perspective

Attachment theory is a developmental theory that explains the nature of the parent-child bond and how this may translate to other relationships in life (e.g. Bowlby, 1958). It proposes that children have a need to form close bonds and that early experiences of such bonds influence interpersonal functioning and emotional regulation in the future. Sensitive and responsive caregivers are associated with a secure attachment style, where individuals' display a capacity to manage distress and form positive relationships with others. Alternatively, insensitive and unresponsive caregivers may lead to increased distress where children attempt to get their needs met (anxious or ambivalent attachment styles), or avoid closeness (insecure, avoidant attachment style) (Bretherton, 1992). There is evidence to support an association between avoidant attachment styles and psychosis symptoms (both positive and negative) and between attachment anxiety and positive symptoms (Gumley et al., 2013). Berry, Barrowclough & Wearden, (2008) demonstrated associations with avoidant attachment and paranoia and proposed that adult attachment styles may predict symptoms, interpersonal problems and therapeutic alliance.

Childhood adversity and trauma

It is argued that voice-hearing 'arrives' as a meaningful reaction to unresolved trauma (Romme & Escher, 200). The emphasis of this perspective is to de-pathologise voice hearing and place value on its content, potential meaning and discover the intentions of voices (Corstens et al., 2014; Longden, 2017). It is therefore argued that that services should be asking 'what happened to you?' rather than 'what is wrong with you?'. Supporting literature argues for life experiences to be better considered when attempting to understand the development of psychotic disorders (Bebbington et al., 2004; Morrison & Peterson, 2003; Read & Dillon, 2013).

It has been proposed that many symptoms have content which can be meaningfully linked to previous experiences that were personally significant (Read and Argyle, 1999; Read & Dillon, 2013; Hardy et al., 2017). Raune (2001) proposed an indirect link, where common themes (rather than direct content) exist between psychosis and historical events. Hardy et al. (2017) explored this further. For 12.5% of participants in the study the themes and content of hallucinations were similar to traumas, for 45%, the themes were the same but not content, and for 42.5% there was no identifiable association.

Read et al. (2001) proposed a 'traumagenic neurodevelopmental (TN) model of psychosis'. Within this, they argued that the heightened stress sensitivity consistently found in patients with psychosis is not necessarily inherited but caused by early exposure to abuse or neglect. This was supported by various brain similarities between abused children and adult schizophrenia patients. There is also considerable overlap between PTSD and psychosis symptomology (Kilcommons & Morrison, 2005) which would further support this model.

Further to this, a review by Read, Van Os, Morrison and Ross (2005) claimed that 'child abuse is a causal factor for psychosis and schizophrenia'. They argued for further research to develop the understanding of mechanisms underlying the link between trauma and psychosis. They also found that there was little focus in clinical practice of asking people about trauma and argued that this should be routine practice.

In criticism, Morgan and Fisher (2007) argued that this proposed causal connection was over-emphasised and not methodologically supported. In their review, psychosis was often grouped with various other disorders, thus limiting the extent of their claims. They did however support the view that those who have experienced trauma have poorer outcomes and the risk of developing psychosis is increased.

In a meta-analysis of 41 studies, Varese et al (2012) found that various adversities significantly increased the risk of developing psychosis, sexual abuse (odds ratio = 2.38), physical abuse (odds ratio = 2.95), emotional abuse (odds ratio = 3.40), bullying (odds ratio = 2.39) and neglect (odds ratio = 2.90). In a further review, Matheson et al. (2012) concluded there was moderate to high quality evidence of increased childhood adversity rates in individuals with a schizophrenia diagnosis compared with a control group or anxiety disorders (Matheson et al., 2012). Whilst broadly summarising as 'childhood adversities', the review was heavily focussed on sexual abuse (explored in all 25 studies) with physical abuse as a second focus (10 studies). Only a small proportion of primary studies reported other adversities (loss, neglect, emotional abuse, witnessing domestic violence).

There are common limitations to these reviews, firstly the primary studies varied considerably in their assessment methods, classification and recording of childhood experiences (their severity, duration, frequency etc.). They also varied in how they assessed psychosis, some using self-report measures and some psychiatric diagnoses, therefore limiting generalisability of findings. However, Varese et al (2012) argued that even considering the various methodological quality parameters, the main effect from the meta-analysis could not be obscured.

Further support of the role of trauma in the aetiology of psychosis comes from population studies. In the British National Survey of Psychiatric Morbidity; individuals who met criteria for a psychiatric disorder were more than fifteen times more likely to have experienced sexual abuse (Bebbington et al., 2004). Although able to draw from a large sample here, measurement was crude with only one question being asked to ascertain abuse (without frequency, severity, or time-period considered).

A Finnish population study concluded that individuals who reported abuse in childhood (sexual, physical, emotional or neglect) were more likely to experience symptoms of psychosis during a three year follow up period (Janssen et al., 2004). They had further explored the severity of abuse and proposed a dose-response relationship, meaning that for individuals who reported more severe symptoms of psychosis, the effect of abuse was the strongest. To focus more on a younger population, Spauwen et al (2006) explored trauma within developmental stages of psychopathology. They supported previous studies, finding that individuals who reported trauma also reported three or more psychotic symptoms within a 42 month follow up period.

Although Bebbington et al (2004) and Janssen et al (2004) reported sexual abuse as a particularly elevated trauma risk, Spauwen et al (2006) found that there was not a significant risk in their younger group. Spauwen (2006) suggested that children often fail to disclose sexual abuse until much later in adulthood, possibly due to fearing retribution, embarrassment, guilt or shame. Spauwen et al (2006) found that instead, the strongest independent risk factors for psychosis symptoms were natural catastrophe and physical threat.

A key challenge of research in this field is the co-occurrence of adversities, for example, a child who is sexually abused is at increased risk of being bullied. It was found that individuals who had experienced two types of adversity (e.g. bullying and sexual abuse), were five times more likely to receive a psychosis diagnosis and those with three types of adversity were thirty times more likely to receive a psychosis diagnosis (Shevlin et al., 2013) Whilst helpful to consider, especially when working clinically with individuals who report multiple traumas, this presents complexity when attempting to explore specific pathways and associations for individual adversities.

In exploring this literature, it was noticed that physical and sexual abuse were most frequently studied yet other common childhood adversities, such as bullying, have received much less attention.

Cognitive models.

Cognitive models attempt to integrate biological views (such as predisposition to psychosis), attachment theory and the role of trauma into the development and maintenance of psychosis (Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001). They form the theoretical basis of the NICE guideline recommended treatment, Cognitive Behavioural Therapy for Psychosis (CBT-P) (Garety et al., 2001; Morrison, Renton, Dunn, Williams, & Bentall, 2003; NICE, 2015). The aim of CBT-P is to reduce the distress of hallucinations or delusions and increase coping with them, rather than targeting the symptom itself. Predominant CBT-P models are outlined below.

Garety et al (2001) postulated individuals who have bio-psycho-social vulnerabilities develop early beliefs, such as ‘I am vulnerable’ and ‘others are abusive’. A triggering event or accumulation of life stressors then leads to a disruption of cognitive processes. This disruption may lead to ambiguous and unstructured sensory input (e.g. a sense of being watched or hearing a voice), followed by unintended memories emerging into consciousness. The person may then struggle to differentiate between internal and external experiences (e.g. I *am* being followed, attacked). This appraisal may be influenced by emotional reasoning (e.g. if it feels true, it must be true) and attributional bias (e.g. jumping to conclusions) or dysfunctional schemas about themselves and the world. The resulting positive psychosis symptoms may then be maintained by ongoing reasoning and attribution bias, how they appraise their symptoms, or emotional responses (e.g. ongoing anxiety, avoidance, selective attention or low self-esteem).

Morrison (2001) proposed an integrative model, applying components of cognitive models of anxiety (e.g. Clark, 1986; Salkovskis et al, 1998). Psychosis symptoms are conceptualised as ‘intrusions’; it is proposed that it is the *misinterpretation* of intrusions (like in anxiety disorders) that create distress, rather than the intrusions themselves. These misinterpretations are often not accepted socially or culturally and are thus understood as psychosis. Symptoms were thought to be maintained by mood, arousal or maladaptive coping responses (e.g. fear and anxiety, safety behaviours, avoidance or hypervigilance). Morrison (2001) proposed that negative beliefs about the self, others and the world (formed from early trauma or adverse experiences), increase vulnerability to misinterpretation and also can be reinforced through these maintenance factors.

Freeman et al (2002) focused more specifically on paranoia and persecutory delusions, also drawing comparisons with anxiety disorders. This was because there is a common theme which is the anticipation of threat or danger. They proposed that a delusion arises when a stressful life event acts as a precipitator to increased arousal, often within a background of longer-term anxiety or depression. If individuals have a vulnerability to psychosis, this increase in arousal may initiate ‘inner-outer confusions’ where thoughts may be experienced as voices or the person experiences subtle perceptual anomalies (Fowler et al., 2006). These experiences then generate an effort to search for meaning which can lead to a threat belief which may be mediated by the person’s social environment, beliefs about illness, or how flexible they are in their belief systems. For example, a person who believes themselves to be vulnerable, deserving of harm, or hold beliefs about the world being threatening and hostile is more likely to experience persecutory beliefs. It is therefore highly relevant to individuals who have experienced trauma in the past.

Cognitive models are not free of critique. It is argued that such psychological models are also pathologising as they still rely on psychiatric concepts. Furthermore, intervention guides are based on an implicit disease paradigm (Maddux, Snyder and Lopez, 2004). Dudley and Kuyken (2006) note an incongruence between how problems are presented as arising from biopsychosocial factors but the core to change in CBT-P is the patient's own perspective and agency. Similarly, Harper (2001) highlighted a risk that individuals in CBT-P therapy may comply with a formulation that places biased cognition at the core of their difficulties, and under-represents environmental factors. This could be received by patients as blaming (Fairfax, 2008). Morrison et al. (2004) however argues that external environmental stimuli are considered in the activation of hallucinations. In a systematic review of the effectiveness of CBT-P, Jauhar (2014) found only a small effect on overall symptom reduction, therefore arguing that claims of effectiveness of CBT-P are untenable and NICE should review its recommendations.

Finally, it is argued that models based on such Western assumptions cannot meaningfully apply to other cultures (Fernando, 2003). In cultural and spiritual perspectives, experiences like voice-hearing are understood as a spiritual crisis leading to personal or spiritual growth (Menezes Jr & Moreira-Almeida, 2010). In addition to being considered culturally insensitive, it is also argued that CBT-P is not sensitive to age or learning disabilities and therefore requires adaptation for different audiences (Collerton & Dudley, 2004; Rathod et al., 2010; Kirkland, 2005)

Summary of Part I: Exploring Psychosis

The first part of this chapter discussed the historical context, definition and diagnostic views and debates around psychosis. This demonstrated the complexities around early psychosis experiences and how they may be represented along a continuum.

The rationale and approach of the EIP model was also discussed. Following this, various conceptualisations of psychosis development were described, from the more dominant medical view to cognitive models.

One of the major areas of research identified was the influence of childhood trauma and adversity. This argues for better consideration in clinical work with individuals who experience psychosis. It was noticed that childhood bullying was highly neglected in adversity research, either omitted altogether or combined in results with various other adversities. For example, in Varese et al., (2012), only 6 out of the 41 studies identified reported specific bullying outcomes; this was less than the number of studies exploring parental death. As around 1 in 8 children report physical bullying in the UK (Office for National Statistics, 2015) and the common onset of psychosis is in adolescence, this was quite surprising. Even more so as bullying is widely accepted to be associated with mental health and it can be traumatic for young people (Espelage, Hong, & Mebane, 2016; Newman, Holden, Delville, 2005; Van der Kolk, McFarlane & Weisaeth, 2007).

Overall, it is argued here that the highly prevalent and potentially traumatic experience of childhood bullying has been neglected from research exploring childhood adversity and psychosis. Therefore, the topic of childhood bullying warrants further attention.

Part II: Childhood Bullying

The concept of bullying is less prevalent in psychosis literature, yet is a common childhood stressor and potentially traumatic, so it is important to focus on this issue in more detail. Firstly, the concept of bullying will be set in historical context and defined, before outlining historical and theoretical perspectives. A critical review of relevant literature which explores associations between bulling and psychosis will then be presented.

Historical context of bullying

Historical literature offers insight into Victorian attitudes of society and early conceptualisations of bullying. 'Tom Brown's Schooldays', published in 1857, famously gave accounts of school bullying experiences where a group persistently targeted a young boy (Smith, 1997). Also, Koo (2007) described an incident in 1885 where a boy died from being bullied by peers and teachers had 'turned a blind eye'. It was considered a misadventure, a normal part of school life. In Scandinavia, the term 'mobbing' (or mobbning in Swedish) was used in early literature to describe groups of children repeatedly harassing, tormenting and ganging up on individual victims (Heinemann, 1972). These early accounts are relevant to current research as they allow us to recognise the importance of social context, when considering such an interpersonal phenomenon. The nature of how bullying may be received by various parties may be subjective and influenced by current societal views.

Defining bullying

Defining and distinguishing between bullying, peer victimisation, harassment and aggression is a challenge. Researchers seem to use these various terms for similar processes. The conceptual definition used in literature for decades is, "when he or she is exposed, repeatedly and over time, to negative actions on the part of one or more other students" (Olweus, 1993). A 'negative action' may be one of physical contact, hurtful words, unpleasant gestures, spreading rumours or social exclusion from a group (Olweus, 1997, 2013). The person who is exposed to 'negative action' has difficulty in defending themselves through size, strength, age or group size. Peterson & Rigby (1999) supported this idea, stating "it is not bullying when two people of the same size or strength have the odd fight or quarrel". Therefore, bullying is often characterised by three minimum criteria; hostile intent (physical, verbal or relational), imbalance of power and repetition over time.

Use of social media and mobile communication, or ‘cyber-bullying’ has emerged as another opportunity to convey hurtful or intimidating messages (Smith, 2012). In a review, it was suggested that the same broad criteria of traditional bullying are used across cyber contexts. However, anonymity and publicity should be considered more relevant in cyberbullying than repetition and power imbalance (Thomas, Connor and Scott, 2014).

Critique of bullying definitions

Whilst a bullying definition is useful for research purposes, the criteria of hostile intent, imbalance of power and repetition over time are problematic concepts. An individual may suffer a single severe incident of abuse that they consider to be bullying, even if a researcher may not. Additionally, if repetition of bullying results in the bully becoming more powerful and the victim feeling more powerless (Pepler, Craig, Ziegler, & Charach, 2009), then the concept of power is subject to circular reasoning.

Terms used interchangeably with bullying are less reliant on such criteria. For example, peer-victimisation is defined as ‘the experience of children being the target of aggressive behaviour of other children, who are not siblings, and are not necessarily age mates’ (Hawker & Boulton, 2000). However, even concepts within definitions, such as ‘aggressive behaviour’ are open to debate and not free from complexity. Rigby, (2002) stated ‘it may seem like splitting hairs to make a distinction between aggression and bullying’ (p.30) but also noted that equating the concepts may be over-inclusive and might misclassify single, random acts as ‘bullying’. It is also argued that definitions should clearly encapsulate the objective of bullies; to socially isolate or humiliate. This is neglected by aggression-focussed definitions (Rigby & Slee, 1991).

There are cross-cultural limitations in current bullying definitions. In a review, Arora, (1996) found that the word ‘bullying’ is not easy to translate in some languages. They also found no consensus among researchers regarding what bullying encompasses.

Additionally, Rigby (2002) found incongruence between the public and researchers' definitions of bullying.

In a focus group exploring definitional distinctions, adolescent participants believed that anything in which a victim was affected should constitute bullying (Nocentini et al., 2010). These issues lead to question how individuals may have become over (or under) classified as bullies or victims in the literature to date. Inevitably this is problematic, particularly when establishing prevalence or using self-report measures.

Study definition of bullying

For the purposes of this study, I will draw from Olweus (1993) but considering the issues discussed, will define bullying as:

"The exposure to a prolonged and repeated period of direct or indirect behaviour of a more powerful individual or group, intended to cause injury, distress, humiliation or social isolation."

This definition is inclusive of methods of ostracism and relational bullying, rumour spreading, social media shaming, racist or homophobic name calling. It will be used as a guide with which to focus the research and review of the literature. However, so as not to ignore adolescent views in the Nocentini et al. (2010) study, a flexible approach will be taken, and the concept will be further explored with participants.

Roles within Bullying

Research often refers to various roles that occur within bullying interactions and divides them into more distinct categories. The most common terminology used is the 'bully' who perpetrates the act, the 'victim' who is the receiver, and 'bully-victims' who take on both roles. The other role is of the 'bystander' who may witness the events and their response may be important to how things develop. Craig, Pepler & Atlas (2000)

reported only 19% of bystanders supported victims. A bystander may act as a 'defender' who helps the victim, an 'outsider' who avoids any involvement or a 'reinforcer' who may join in by cheering or laughing (Salmivalli et al, 1996). The 'law of silence' may apply where individuals are too worried about reporting it due to fear of becoming a victim (Ortega, 2010).

Impact of bullying

In a review, Arseneault et al. (2010) concluded that exposure to bullying contributes to children's mental health over and above any biological, family factors or pre-existing mental health difficulties. Bullied children are initially more likely to report poor sleep, bed-wetting, head and stomach aches (Monks et al, 2009). Bullying has also been associated with reduced self-esteem and elevated symptoms of depression and anxiety (Hawker and Boulton 2000). Higher rates of self-harm have been found in bullied individuals (Fisher et al, 2012; Lereya et al, 2013) along with increased suicidal thoughts and attempts (Herba et al., 2008).

Poor outcomes for bullied children were found to remain present, even after controlling for prior adjustment problems or genetic and family confounds (Arseneault et al, 2008). This indicates an environmentally mediated effect on the development of mental health difficulties from bullying. Longitudinal cohort studies have found that children who were bullied are at risk of a wide range of long term poor social, health and economic outcomes, even four decades later (Klomek et al., 2009; Takizawa Maughan & Arseneault, 2014)

Avoidance, intrusive thoughts, dissociative experiences and nightmares have all been identified in individuals who have been bullied (Carney, 2008; Mynard & Joseph, 2000; Scott and Stradling 1992; Weaver 2000). Other traumatic responses associated with bullying are the loss of trust (Janson & Hazler, 2004), significant helplessness and fear

(O'Brien, 1998). Furthermore, it is argued that as well as avoidance, victims of bullying may show blunted affect and loss of interest in activities (Davidson, Inslicht & Baum, 2000; O'Brien, 1998). These findings further argue that bullying should not be neglected in childhood trauma research.

To further explore the concept of bullying, the underpinning theoretical constructs will be discussed.

Theoretical Context

Various psychological theories have been drawn upon to further understand the concept of bullying. Social and attachment perspectives will first be presented as these are most common in bullying literature. Cognitive theory will then be explored to consider how bullying may fit within psychological frameworks of understanding psychosis.

Social perspective

Social theories consider the importance of social group membership; these have been found to be of considerable significance by age 5-6 (Nesdale et al., 2008). It is thought that this is driven by a fundamental need to belong (Baumeister & Leary, 1995) and a pre-occupation with how one's appearance is perceived by peers (Jones, 2012). One of the theories that links social and psychological concepts is Social Rank Theory.

Social Rank Theory proposed that two psychological systems function in social groups, a 'social rank system' and a 'safety system' (Gilbert et al., 2003). It is thought that a 'social rank system' has an evolutionary function of social control and allocating social resources. Individuals adopt positions of submission or dominance. On the other hand, the 'safety system' is based around opportunities to connect and cooperate, rather than compete. Within groups it is thought that individuals consider sameness and difference to other members, leading to making 'in-group' or 'out-group' distinctions (Brown, Vivian, &

Hewstone, 1999). Therefore, group belonging, and acceptance often depends on the ability to conform to group norms (Stevens & Price, 2015).

Being rejected from groups through bullying creates a threat because individuals are not accepted or approved of. Thus, they may see themselves as undesirably inferior, less attractive and an outsider. It is the involuntary, unwanted nature of the social position that is crucial in its associations with shame, social anxiety or depression, rather than the position itself (Gilbert, 1992). Losing peer support at a time when peer relationships are most important may lead to lower views of self and others (Schäfer et al., 2004); this leads us to consider theories of attachment.

Attachment perspective

For children, peer relationships may be particularly affected by attachment style (Nordling, 2014). In general, children who are secure in attachment thrive socially, whereas those who are insecure in attachment struggle with peer relations (Berlin, Cassidy, & Appleyard, 2008). It has been found that bullies tend to display an avoidant attachment style (Monks et al., 2009); victims tend to be fearfully attached and find it hard to trust (Shafer et al., 2004). Attachment perspectives would suggest a relative continuity of the role of the bully or victim over time. However, a child may be a victim at school but a bully elsewhere (Ryoo, Wang & Swearer, 2015). Attachment theory does not explain these differences, nor does it adequately reflect relational interactions within school or wider community systems.

Cognitive perspective

The cognitive perspective is less considered in bullying literature than social and attachment narratives. The contribution most frequently made by cognition focuses on bully behaviours, i.e. how individual cognitive and social distortions may lead to bullying

aggression (Crick and Dodge, 1994). However, as bullying can be viewed as a form of childhood adversity, it may be helpful to consider its relevance within cognitive models of psychosis.

Childhood trauma or adverse experiences are thought to lead to negative schemas of the self and others, thus influencing the appraisal of other stressors (Freeman et al., 2002; Garety et al., 2001; Morrison 2001) So, a person who is bullied may believe that they are vulnerable or that the world is threatening and hostile. Individuals who hold such beliefs are thought to be more likely to experience persecutory beliefs (Freeman et al, 2002) or more vulnerable to misinterpreting external stimuli (Morrison, 2001).

These types of beliefs are also known as 'victim schemas' and are presented by Rosen et al (2007) in a Victim Schema Model. This suggests that children who experience bullying develop an implicit 'schema' of themselves as victims. Children may then respond to other situations with biased cognitions, behaviours and emotions consistent with being a 'victim'. This self-fulfilling prophesy means the child interprets a peer as 'threatening', so responds in ways consistent with the victim role and then is victimised as a result (Crick & Dodge, 1994; Perry, Hodges & Egan, 2001; Rosen et al., 2007). Therefore, a victim-schema increases the risk of future victimisation (Rosen et al, 2007)

Selten and Cantor-Graae (2005) considered bullying amongst a range of other childhood adversities associated with psychosis and hypothesised that they all share common concepts such as 'social defeat'. A certain attributional style; the way people explain to themselves why events occur, has been implicated in this relationship. This is 'locus of control' and refers to the degree of confidence individuals have in controlling events that affect them. These can be considered internal (derived from their own actions), or external (where others are seen to hold the responsibility or control) (Rotter, 1966).

Fisher et al., (2012) suggested that an 'external locus of control' represented a main pathway in the association between bullying and psychotic symptoms.

Relationships between bullying and psychosis

Having considered the theoretical context, to offer further focus to the topic of bullying and psychosis, empirical literature was explored. This was carried out by focusing on the most prominent published reviews of the extant literature. These reviews are summarised in Appendix A, Table 1. They are also narratively explored below:

Clinical vs non-clinical populations

In a meta-analysis, Van dam et al. (2012) explored whether childhood bullying was related to the development of clinical or non-clinical psychotic symptoms. Non-clinical samples were defined as those identified in general population; clinical samples were those who had 'at least one contact with a mental-health service'.

In non-clinical samples, they supported bullying as an aetiological determinant of psychosis development. They also supported a 'dose-response' relationship whereby the risk of developing psychosis and the persistence of symptoms, increased with the frequency of bullying (e.g. Lataster et al. 2006; Schreier et al. 2009; Mackie et al. 2011). However, the results were less conclusive for clinical samples. Only four studies were identified (Bebbington et al., 2004; Sourander et al., 2007, 2009; Luukonen et al., 2010) and overall, they failed to offer consistent support for a relationship between bullying and psychosis. Van dam et al. (2012) therefore suggested the clinical sample evidence was 'inconclusive' and warranted further research.

The review was considered of good quality with a clear aim, a widely inclusive search strategy and clear reporting. However, they did not assess or comment on the quality of primary studies. Furthermore, defining a clinical sample as 'at least one contact with

mental health services' may be over-inclusive. Clinical samples were still drawn from a population study and a birth cohort study where the nature of contact with services was not clear.. Only one study included participants actively recruited from a clinical service (Luukonen et al., 2010); they found no significant association between bullying and psychosis. Arguably, these may not be such distinct clinical groups. This suggests that the clinical samples in this review aren't fully representative of individuals who access services for help with psychosis experiences.

Finally, the overall number of studies reviewed was too small to draw conclusions, complicated by a variation in measurement tools, methodology and short follow-up, limiting the ability to explore patterns over a lifespan.

Longitudinal research

Addressing some of the limitations of Van dam et al. (2012), Cunningham, Hoy and Shannon (2016) used a prospective design (following a cohort over time) to explore the association between childhood bullying and psychosis longitudinally. They found ten studies (although four used the same data-set from the Avon Longitudinal Study of Parents and Children (ALSPAC)). Overall, the review found that childhood bullying increased the likelihood for the later development of psychotic symptoms. Also, a dose-response effect of the accumulation of negative experiences was supported. One of the reviewed studies found that if bullying reduced or stopped, then psychosis experiences also decreased (Kelleher et al., 2013). This has potential implications for early intervention in bullying.

Cunningham et al. (2016) emphasised other potential mediators in the relationship between bullying and psychosis such as self-esteem, locus of control, anxiety or depression. They highlighted the complexity in trying to ascertain a developmental pathway in psychosis. This review offered clear quality appraisal of primary papers, however was limited by the small number of studies identified and differences in measurement and time

frames (ranging from 2-10 years). Being longitudinal in design, this review relied upon population and cohort studies, predominantly using self-report measures for psychosis experiences. Therefore, the included papers may be limited in being representative of those who may have sought help for their psychosis experiences.

Bullying and paranoid thinking

In the most recent review, Jack and Egan (2017) explored the association between bullying and paranoid thinking. Nine out of the ten identified studies found a positive association. Sample sizes were relatively small, except for two epidemiological studies (Bentall et al., 2012; Shelvin, McAnee, Bentall & Murphy, 2015). Whilst these epidemiological studies reported large sample sizes, they did not use validated measurement tools for either bullying or psychosis variables. Jack and Egan (2017) included unpublished studies, noting the lack of literature available. They concluded that there was evidence to support the hypothesis that childhood bullying precipitates development of paranoid thinking, and some evidence to support a dose-response relationship. However, as the research base was not high quality, this was a cautious conclusion. Whilst this study did include some samples recruited from mental health services, the majority (73%) of the sample was from school pupils or undergraduate student populations. This highlighted the lack of studies identified that had been carried out for those who had accessed clinical services for help. It is argued that those who access services are an important omission from previous reviews. Those who have been identified as having 'psychosis-like experiences' through self-report tools in the general population may not have sought help for their experience or may experience psychosis as less severe or less distressing than those in services. It is further argued that professionals working with early psychosis populations would benefit from awareness of research which more

accurately represents the groups with which they work. None of the reviews to date have met this need and therefore this is identified as a clear gap in the review literature.

Summary of Part II: Childhood Bullying

The definitional ambiguity around bullying was discussed, in line with its complexities in research contexts. The impact of bullying was found to be significant for young people and linked to various mental health difficulties. Theories of bullying were presented, with possible theoretical links between bullying and psychosis explored. Finally, current reviews exploring the relationships between bullying and psychosis were critically evaluated.

Overall, reviews published to date have identified a positive relationship between bullying and symptoms of psychosis, but this is only true in non-clinical, general population samples. Research in clinical samples where individuals have sought help for psychosis experiences was found to be scarce and inconsistent. Situating bullying associations solely within non-clinical samples limits the application of the findings to services offering psychosis treatment.

Part III: Systematic Review

Rationale for systematic review

Systematic reviews are essential in summarising evidence with more accuracy and reliability (Khan, Kunz, Kleijnen, & Antes 2011). The consensus across the literature is that there is a consistent relationship between childhood bullying and ‘non-clinical symptoms’ of psychosis. However, reviews to date have highlighted a lack of high-quality papers exploring a possible association in more distinct clinical samples where treatment is offered. As previous reviews found very few studies in well-defined clinical groups and

relevant research may have been published recently, there was sufficient rationale to update the Van dam et al. (2012) review focussing specifically on clinical populations.

Clinical populations are defined for this purpose by recruitment through mental health services, irrespective of diagnosis. This was to ensure that a potential younger population, who are highly relevant to the topic but may not have received a psychosis diagnosis, were included (some EIP services argue against offering diagnosis for young people).

Aim

The aim of this review is to explore the evidence base for the relationship between childhood bullying and psychosis in clinical samples (individuals who are engaged with mental health services and report psychosis experiences). The following questions were set:

1) What is the quality and design of studies exploring the relationship between (or role of) childhood bullying and psychosis?
2) Is there an established association between childhood bullying and psychosis for individuals who are currently accessing help from mental health services?

Method

For transparency and to retain clarity in the process of this systematic review, guidance from the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Group was followed (Moher et al., 2009).

Search strategy

Four electronic databases were searched in August 2018; CINAHL Complete, MEDLINE with Full Text, PsycINFO and PsycARTICLES. To ensure the search was thorough, search terms aimed to encapsulate studies that may have included bullying within

a broader research context, such as adverse childhood experiences. All years were included Appendix B Table 1 outlines the terms and articles identified relating to each search. Records found were then screened based on relevance to the review question and inclusion and exclusion criteria (see Appendix B Table 2). This was first by title, then abstract, then by full text. Reference lists of relevant articles were also hand-searched (see Appendix B, Figure 1).

Authors were contacted to answer queries over sampling and request restricted-access papers. A potential study, Magaud, Nyman and Addington (2013) clarified they used a non-clinical population sample and it was therefore excluded. Bird et al (2017) were asked to clarify their procedure; no response was received.

Approach to synthesis

Meta-analysis is a common approach used to combine the results of several papers to create a single more precise estimate of effect. However, this approach requires homogeneity in the primary studies. The papers identified in the current search were widely varied and therefore this criterion for homogeneity was not met. It is argued that a meta-analysis of badly designed or heterogenous studies can be misleading as it only acts to produce erroneous statistics (Eysenck, 1994). Therefore, a narrative synthesis was considered to be better suited to bring together results from primary studies. The defining feature of narrative synthesis is to adopt a narrative to summarise the current state of knowledge in relation to the review question (Popay et al., 2006). Guidance relating to narrative synthesis was followed throughout (Arai et al.,2007; Popay et al., 2006).

After discussing quality appraisal of included papers, a summary of study designs will be discussed, including reference to the outcome measures used. Finally, a

synthesis of the main findings will be presented, grouped according to design. Findings of the systematic review will be discussed along with strengths and limitations.

Quality was appraised using The Critical Appraisal Skills Programme (CASP) tool (2013). This was not to exclude any papers of poor quality as the research base is limited, it was used to consider strengths and limitations of each study. The authors do not suggest using this tool as a scoring system but to systematically assess the trustworthiness, relevance and consider contribution to the overall research question. These concepts will be referred to throughout the synthesis.

Results

Included papers

Ten papers met inclusion criteria. Study characteristics are summarised in Appendix C Table 1. They are grouped as correlational, case-control, and mixed model papers. Two papers used the same sample but were retained for review as they explored different aims and reported results from different measures (Valmaggia et al., 2015; McDonnell et al., 2018).

All studies were published within the last five years with most studies published last year, perhaps reflecting developing interest in the topic. They were all carried out within Europe, mainly in the UK or in Italy with one study based in Finland and one in Ireland. The search terms were checked to ensure that this result was not due to language differences; international terms (e.g. mental illness, victimization) were included so should not have limited results. Sample sizes ranged from 16 with thematic methodology (Catone et al., 2016) to 337 within a case-control study (Trotta et al., 2013).

There was a relatively even spread between male and female participants, except for the Bird et al. (2017) study where participants were predominantly female. Of the

studies that reported ethnicity, most participants were White-British. However, Valmaggia et al. (2015) and McDonnell et al. (2018) included more diverse samples. The studies were all based within adolescence or young adulthood. The youngest sample mean was 13 years old (Catone et al., 2016) and the oldest sample mean was 28 years old (Trotta et al., 2013).

Exploring quality and design of included papers (Aim 1)

Quality appraisal

The Trotta et al. (2013) and Catone et al (2016) studies were considered the highest in quality when considering contribution to the review aims. For Trotta et al. (2013) this was due to large sample size, clear focus on clinically relevant psychosis populations, representative recruitment procedures, extensive analysis including power calculations and clear presentation of results, highlighting their limitations. However, their lack of a validated measure for bullying may still limit the validity of findings.

The main strengths of the Catone et al (2016) study included their qualitative focus on experience and content, thus improving the depth of information than could be gained from other studies' quantitative methodology and ambiguous measures. Clinicians were blinded to the purpose of the study, reducing bias and it was the only study in this review where data was corroborated with others (parents, carers, teachers). They also were unique in studying content of psychosis experiences in children and adolescents; previous research of this nature had only been in older samples (Goff et al. 1991; Hardy et al., 2005; Read and Argyle, 1999). However, as the sample was small and from one clinical unit, results cannot be generalised, although this was not the purpose.

Studies considered the weakest in terms of claims made by their results were Masillo et al., (2016) and Bird et al. (2017). Masillo et al., (2016) presented what appeared

to be a relatively large sample of 147 help-seeking adolescents' yet only 20 participants within the sample had experienced bullying so the sample size of interest was very low. Regardless of this, they reported results from multiple regressions and made significant conclusions around bullying being an independent predictor of paranoid ideation and suspiciousness.

A criticism of Bird et al. (2017) was the lack of clarity in methodology. Various measures were completed by participants (for affective symptoms, worry, insomnia, negative self-beliefs, affective reactivity) which would have resulted in 174 items plus a PANSS interview and a jumping to conclusions task. It was not stated how, by whom or over what time period these were carried out.

An overall strength of included studies was that they are all recent and therefore offer an up-to-date contribution to the literature.

Design of included papers

Nine of the studies used a quantitative approach. One study (Catone et al., 2016) used a mixed-model methodology which aimed to extrapolate associations between life experiences and the content of psychosis experiences. As the authors made explicit and detailed reference to bullying and psychosis variables; it met inclusion criteria.

Explanations for the lack of qualitative studies resulting in the search were considered. It is argued that systematic searches for qualitative research have limited value (Barroso et al., 2003). This may be due to how concepts are defined and conceptualised in qualitative research (Evans, 2002). However, to allow for deficiencies in this process, the search terms used were broad, did not specify any terms that might bias quantitative designs and complementary reference search methods were used. As this still failed to identify any

relevant papers, it is most likely that there are no articles to date using qualitative methodology on this topic.

Eight of the papers were cross-sectional in their design, with one paper using longitudinal design (Bird et al., 2017). Although longitudinal, the study follow-up period was only three months, thus limiting the ability to detect maintenance or changes over time. Whilst larger prospective studies have been identified in the general population (see Cunningham, Hoy & Shannon, 2016) the outcome of this search highlights the lack of prospective studies using clinical samples.

Critique of outcomes and data collection strategies

Some key strengths and weaknesses were found around the use of measures. Several studies used validated measures for both bullying and psychosis and reported on their reliability (Bird et al., 2017; Catone et al., 2017; McDonnell et al., 2017; Valmaggia et al., 2015). The approaches considered the best quality gathered and analysed information on time points of bullying (primary and secondary school) and different forms (e.g. verbal or physical) (Catone et al., 2017; McDonnell et al., 2017; Valmaggia et al.; 2015).

There were an equivalent number of studies without measures, with analysis based on the use of a single question, such as 'Were you bullied at school?' (yes/no), which gave no information on the frequency, severity or type of bullying (Lindgren et al., 2017; Masillo et al.,2017; Trotta et al., 2013). Due to the definitional ambiguity of bullying, asking if someone has ever experienced it 'once' in their lifetime might overestimate the prevalence.

Psychosis measures were also examined more closely. The Structured Interview for Psychosis-risk Syndromes (SIPS) (Miller et al., 2003) includes questions about whether the person felt people were talking negatively about them, feeling mistrustful, needing to

pay attention to others to feel safe, feeling singled out or feeling people are intending to harm them. It seems logical that someone experiencing, or who recently experienced bullying would give a positive response to these questions without this indicating any specific pathology. With most of the sample being in education (from age 12, mean age of 17), it is also possible that they were still experiencing bullying and reporting actual targeting rather than 'ideations'. Furthermore, across the whole sample a very low score was recorded on the SIPS reporting only 'doubtful low-level symptoms' therefore leading to question the papers claims in the context of psychosis presentations.

Similarly, Bird et al (2017) claimed that peer bullying and cyber-victimisation predicted 'paranoia persistence' using the Green Paranoid Thoughts Scale (GPTS). The scale consists of questions about social experiences and feeling persecuted (e.g. people have laughed at me behind my back, I was convinced people were singling me out, certain people were hostile towards me). With an average age group of 14, respondents could be reporting true bullying, rather than 'paranoia'. It is therefore argued that the relationships reported in these papers may be measuring overlapping constructs rather than a distinct predictor of psychosis.

O'Connor et al. (2017) extracted information from clinical files instead. This is also problematic as it relies on clinician to ask the relevant questions and record responses. Review findings suggest most cases of abuse are not identified by clinicians, people with psychosis are asked less than others and only 28% of abuse cases were recorded in files (Read, Harper, Tucker & Kennedy, 2018). Therefore, although self-report measures are limited in scope, and gaining any depth of experience, they benefit from asking questions of interest directly.

Exploring relationships between bullying and psychosis (Aim 2)

As the primary studies could be broadly grouped according to their design, the synthesis will first examine findings from correlational studies, followed by case-control studies and finally the mixed-model synthesis.

Correlational Studies. All studies reported positive relationships between bullying variables and psychosis variables. The strongest reported relationship was between peer bullying and paranoia persistence with medium to large effect sizes (Bird et al., 2017). Catone et al. (2017) and Masillo et al. (2016) supported the relationship between bullying and paranoia, however McDonnell et al. (2017) found that there was only an indirect effect. They found that bullying predicted interpersonal sensitivity which in turn predicted paranoid ideation and this was also only true if the bullying was severe. This raises an important distinction between severity and frequency which other studies neglected.

Catone et al. (2017) was the only study reporting additional variables to paranoia. They found a weak positive correlation between childhood bullying and hearing voices. They also found verbal bullying was significantly associated with paranoia and social manipulation, whereas physical bullying was significantly associated with grandiosity.

Case-control studies. These studies compared groups of participants meeting criteria for 'FEP' (Lindgren et al., 2017; Trotta et al., 2013) or at 'Ultra High Risk' for developing psychosis (O'Connor et al., 2017; Valmaggia et al., 2015). In most papers, the authors made considerable efforts to recruit a matched control group that was representative of the general population and therefore had clear distinct groups for comparison. One paper however, recruited a control group from individuals who had accessed a clinical service for mental health needs but had not 'transitioned' to meet criteria

for UHR for psychosis, therefore not being representative of the general population (O’Connor et al., 2017).

The prevalence of childhood bullying was consistently significantly higher in the clinical groups than in control groups across all studies. Trotta et al. (2013) found that individuals who experienced FEP were twice as likely to report bullying than healthy controls; this relationship was found to remain significant even after adjusting for other life events or controlling for cannabis use. This was supported by the other FEP study in this group (Lindgren et al., 2017)

It was found that those who are considered UHR or CHR were five times as likely to report bullying (O’Connor et al., 2017; Valmaggia et al., 2015). This is a much higher likelihood than was seen in FEP or diagnosed disorders and may be explained by differences between these populations (see review Van Os and Guloksuz, 2017). These studies may have also overestimated the effect as their sample size was much smaller.

On exploring associations with more specific symptoms, O’Connor et al. (2017) found that childhood bullying was associated with increased odds of experiencing hallucinations and this remained significant when controlling for auditory, visual and other experiences separately. Perceptual abnormalities have been found to be one of the most prevalent symptoms in those at risk of developing psychosis (Cannon et al., 2008; Mason et al., 2004). It was found that those who had been bullied were significantly more likely to report paranoia than those who had not (Valmaggia et al., 2015).

In contrast, Lindgren et al., (2017) found no significant associations when exploring specific symptomology. However, as measurement and methodology varied, there is a need to be cautious in drawing crude comparisons across included studies. The Lindgren

et al. (2017) paper also explored the accumulation of various adversities, finding that the occurrence of several adverse events was typical in those with FEP but not in controls.

Mixed-model. Catone et al. (2017) found a 'thematic link' that connected certain elements of the content of delusions and previous life experience. In 93.7% of patients, socially or emotionally threatening traumatic events occurred before the onset of psychosis. They also found a significant association between persecutory delusions and humiliating experiences with bullying being the most common humiliating experience. They did not find statistical significance in any other associations, suggesting there may be a specific role of humiliating experience in developing delusions with persecutory or threatening content. Although benefiting from exploring thematic content, the analysis coded data to enable statistical analysis between historical events and delusion content. Therefore, depth of the original data may have been over-simplified. The authors had however noted this methodology was not well-established or validated.

Discussion

Overall the review found a positive association between childhood bullying and psychosis symptoms, supporting previous review findings (Van dam et al., 2012, Cunningham et al. 2015, Jack and Egan, 2017). Correlational studies supported the relationship, apart from the Luukonen et al. (2010) study. This might be explained by the inpatient sample of diagnosed psychotic disorders, when other study samples were community CHR or FEP patients. Without control groups in the correlational studies, results need to be interpreted with caution.

The potential role of bullying in psychosis was better supported by case-control studies where a consistently higher proportion of bullied individuals was found in clinical groups, compared with controls. The findings also supported dose-response relationships

found in previous literature (Van dam et al., 2012). Finally, Catone et al., (2016) offered strong support for persecutory content in delusions being precipitated by humiliating experiences, predominantly bullying. This supports prior research of phenomenological links between life events and psychosis experiences (Goff et al. 1991; Hardy et al., 2005; Read and Argyle, 1999).

A limitation of this review is that cross-sectional studies cannot offer information around the development of psychosis over time. Additionally, there was a broad lack of data about other abuse histories; most studies did not control for this. Furthermore, the findings do not offer information over the direction of the relationship between bullying and psychosis. It may be that children who are already vulnerable or have relatives with diagnoses of psychosis appear as different and thus attract bullying (Sideli et al., 2012). Furthermore, individuals who experience psychosis are more likely to experience increased stigma (Karidi et al., 2010; Wood et al., 2014), feel disempowered or socially excluded (Pitt et al., 2009), or socially marginalised (Dinos et al., 2004).

The heterogenous nature of the included papers provided a limitation in offering a coherent synthesis of findings. Studies were however more homogenous in demographics. As participants were predominantly in adolescence, individuals were less subject to recall bias and are likely to be closer in time to their experiences of childhood bullying. They are also less likely to have experienced any long-term effects of anti-psychotic drug use.

Most of the data included from primary studies was through retrospective accounts of individuals, with only one study verifying accounts with others (Catone et al., 2016). Some argue that retrospective studies of experience are biased due to forgetting, depressed mood, subsequent events, or the detachment from reality often associated with psychosis (Fisher et al., 2009). However, it is not thought that these are sufficient reasons to discount the results from studies (Hardt & Rutter, 2004). In fact, reliability has been demonstrated

over time (Goodman et al., 1999) and no difference was found in reliability between reports made by the general population or those with schizophrenia diagnosis (Darves-Bornoz et al., 1995) or FEP (Fisher et al., 2009).

This review included studies exploring psychosis-like experiences or CHR populations. It is possible that findings are misclassified under an umbrella of psychosis when they are not; there is wide debate on this issue. It is argued that these samples may represent individuals with other common psychopathologies (e.g. anxiety, depression, PTSD) with a degree of, or subtle admixture of, psychosis (Van Os and Guloksuz, 2017). This leads to various complexities and raises questions of how data is interpreted in relation to psychosis.

The review was limited by not having a co-reviewer. This would have had the advantage of reducing potential researcher bias. For example, the screening and selection of studies may have been influenced by personal pre-assumptions or knowledge and the definition of bullying offered for the study. A co-reviewer may also have been helpful in assessing quality of primary studies. Although quality appraisal tools are useful in guiding this process, the resulting evaluation remains subjective and may differ according to individual perceptions. These studies were scrutinised with a very critical lens and another researcher may have brought different ideas or noticed further strengths in the primary papers. Furthermore, the results were synthesised and grouped in the way they made most sense to the primary researcher, however another reviewer may have considered a different approach more useful.

Finally, the review was not pre-registered with a public science registry such as PROSPERO or Open Science Framework. By excluding the review from these international lists of prospective research, there is a risk of duplication of effort where

others may carry out similar reviews. Furthermore, being transparent in review aims and objectives through these platforms reduces the risk of bias in reporting results.

Conclusions

Previous literature had established a clear association between bullying and psychosis in non-clinical samples with scarce and inconsistent results in clinical samples. This review has added to the literature by supporting a possible association between bullying and psychosis in clinical samples. It has however also highlighted the paucity of high-quality research and found various limitations in methodology, especially in the use of crude measurement tools or simplistic questions to explore complex experiences of both bullying and psychosis. The constraints of these generic measurement tools also limit the ability to explore the more phenomenological areas of bullying (e.g. reasons for being targeted).

The proposed thematic link between historical experiences and the content of psychotic symptoms supports the view that more in-depth research is required to better understand bullying in this specific population. The nature of the proposed association between bullying and psychosis experiences (and whether it is meaningful), was a clear omission in the studies reviewed.

Part IV: Current study

Summary Rationale

The role of childhood bullying for individuals who experience psychosis has been identified as a gap in the literature. Previous research has focussed on the victim-bully dyad, neglecting the fact that bullying occurs within a wider system of complex social interactions. Crude measurement tools have so far identified relationships between

bullying and psychosis but offered limited insight into the more phenomenological areas of what are two complex constructs.

No research was identified that developed ideas of how individuals with psychosis presentations have made sense of their experience of bullying and the meaning it may hold for them. Nor was research found which explored whether individuals considered bullying to be relevant in their experiences of psychosis.

It is therefore proposed that there is a need for further research to explore the role of childhood bullying in those who experience psychosis. It is thought that a FEP population, aged 14-35 is best suited for further research. This is based on previous recommendations that they are closer to the age group in which bullying occurred (less prone to recall bias) and will be a more homogenous group than those who have long histories of psychosis and medication. The clinical implications would therefore include informing early-intervention services about the potential subjective experiences of patients. Considering the wider system, it may also help to inform schools or families. Kelleher et al. (2013) proposed that detecting or responding to bullying early can reduce the risk of psychotic like experiences in adulthood.

Aims and Objectives

The aim of this research is therefore to explore the subjective experiences of childhood bullying for individuals accessing services for FEP. A secondary aim is to explore whether individuals feel their bullying and/or the recalled responses from others in the wider system (school, family, peers) is relevant to their current mental health, or more specifically, their experience of psychosis.

Research Questions

Following on from the aims, the research questions are:

How do individuals who access services for FEP make sense of their experiences of bullying in childhood?

Do individuals consider their early experiences of bullying to be relevant to their experiences of psychosis? If so, to what extent?

CHAPTER TWO: METHODOLOGY

Overview

This chapter outlines the methodology for the study. It first explains the rationale for using a qualitative approach and discusses the methods that were considered in meeting the research questions. The theoretical foundations of the chosen method, Interpretative Phenomenological Analysis (IPA) will then be explained, along with the study procedure and stages of analysis. Finally, ethical considerations, quality and dissemination will be explored.

Rationale for a qualitative approach

Quantitative research uses numbers as data and analyses them using statistical techniques, usually seeking to identify relationships between variables, to generalise to wider populations. In contrast, qualitative research uses words as data, generating narrow but detailed and complex accounts, seeking to understand and interpret more individual meanings (Tolich & Davidson, 2003).

Quantitative studies have been useful in establishing important associations between bullying and psychosis experiences but have only produced a fragmented picture. This is due to the nature of quantitative research which can neglect the experience in the wider context (Hamburger, Basile, & Vivolo, 2011). Thus, bullying positioned in school, friendship or family networks is missing. Measurement tools also limit the ability to explore the more intricate areas of bullying (e.g. different forms, reasons for being targeted, individual responses). Qualitative material is more able to advance the phenomenology of these contextual factors and broaden research (Sofaer, 1999). It can provide opportunity to develop an idiographic understanding of what it means for participants to be in a

particular situation, or live with a particular illness, within their own social reality (Bryman, 1992).

Psychosis is a complex bio-psycho-social phenomena and definitions of bullying are varied and ambiguous. Qualitative methodology's commitment to first person accounts and concern with phenomenology could provide insight into the experience of such 'real world problems' (Banister, 2011). A further advantage of qualitative design is that it may allow for the emergence of unanticipated findings in what seems to be an under-researched area (Barker, Pistrang, & Elliott, 2002).

Application in clinical settings was also considered. Quantitative methods might appropriately aim more towards treatment outcomes or informing clinical governance and planning documents. However, a qualitative approach will better facilitate the viewpoint of patients in their treatment. Findings will need to be translated to clinical staff to develop their knowledge, aiming to improve their working practices. With the above considerations and the research question in mind, it was clear that qualitative design was most suited.

Philosophical underpinning

A research approach includes various dimensions, ontology, epistemology, methodology and methods. Each of these dimensions can impact how projects are conceptualised and how a study is conducted (Ritchie, Lewis, Nicholls, & Ormston, 2013). Methodological choices are informed by a researcher's philosophical belief system, their ontological and epistemological position. Therefore, to focus on a specific qualitative approach, these were considered.

Ontology and Epistemology

Ontology is a philosophical construct which refers to the study of being (Crotty, 1998). Ontological assumptions are therefore concerned with what constitutes reality, in other words 'W*hat is'*, or what can be said to really exist? Researchers need to take a position regarding their perceptions of how things really are and how things really work (Willig, 2013). For example, some might assume that the social world is predictable and there is a pattern of truths ready to be discovered; others might believe that reality is more fluid and is continually being constructed through social interactions.

Epistemology is the study of *how* knowledge is acquired, and the nature of such knowledge (Crotty, 1998). It therefore seeks to find out what is known, how it is known and what it means to know. Guba and Lincoln (1994) explain that epistemology asks, what is the nature of the relationship between the would-be knower and what can be known? So, in researcher-participant relationships, if something does really exist, how can I, as researcher know that?

To explore my own position, social constructionist, constructivist, realist and critical realist positions were considered. When exploring these, I held in mind a reflective framework; What kind of knowledge do I aim to create? What are the assumptions that I make about the world? How do I conceptualise my role as researcher in the process? What is the relationship between myself and the knowledge that I generate? (Willig, 2013).

Social constructionism. This perspective believes that the way the world exists as it does is due to social and interpersonal influences (Gergen & Davis, 1985). Social constructionist researchers are therefore concerned with 'constructions' rather than 'descriptions', i.e. how people construct and adopt meanings of reality through language. They have been compared to architects exploring how concepts are constructed and from

what materials (Willig, 2013). The type of knowledge created would therefore not seek to find out about how things really are or the way they are experienced, but the process in which the knowledge was constructed. In this context, this approach may be well suited to exploring how 'bullying' is discursively constructed.

Constructivism. A constructivist perspective considers the observer as the creator of reality, giving meaning to what is observed (Jonassen, 1991). We can therefore never have objective access to the world. A constructivist researcher therefore, considers the participant reality as being construed through the researchers experience of it. Furthermore, an individual's interpretation or construction is considered as 'true' as another (Zimmerman & Dickerson, 1994). In this sense, there are multiple realities to a certain context. Knowledge is understood to be the by-product of social interactions, so a researcher cannot remain objective and detached (Ponterotto, 2005).

Critical realism. This position argues that there is a real world out there, but there is no way that such an assumption can be proved or disproved (Easton, 2010). It assumes that this reality is complicated and therefore would not take participants accounts at face value (as a more 'naïve' or 'direct' realist approach might). Instead, it proposes that it might be necessary to 'dig deeper' to understand the underlying structures behind the phenomena that is being explored (Willig, 2013). It differs from a social-constructionist approach as although it also recognises social roles and context are important in shaping knowledge, it does not deny that a 'real' world exists. Critical realism differs from constructivism in its ontology, i.e. critical realism assumes there is an external reality (realist ontology), whereas constructivism assumes a social, or multiple realities. Critical realists therefore argue that rather than take a participants account at face value, where they may not be aware of these underlying structures shaping their behaviour, the researcher should also interpret what they say. This was thought to be particularly relevant in this study as the accounts of

participants will be based within a context of social roles, class, family and school structures, all which may have enabled, or limited their experience.

Reflexivity

This refers to a critical reflection on the research process and involves consideration of one's role and one's relation to knowledge (Braun & Clarke, 2013). It also refers to the commitment to play an active role in the research process (Reid, Flowers, & Larkin, 2005). Therefore, to further consider my epistemological position, I explored the relationship between myself and the knowledge I aim to generate.

Gadamer (1975) considered us to each hold a set of presuppositions and beliefs which make up a 'horizon' or 'sphere' of understanding. I believe that it would be unfeasible to separate out my own 'sphere' when learning about other's experience. I therefore take the view that knowledge will be a co-construction; an interpretation of their story. To explain my position or 'sphere' and how this may impact the research process, critical self-evaluation is imperative. Finlay (2003) proposed that researcher characteristics (e.g. race, gender, personal experience) help to make this stance explicit.

I am a White British female. I was born in Kenya and although I only lived there as a young child, my experience and subsequent interest in travel leaves me curious about culture, race and class structure. I therefore consider context to be an important part of human experience.

I attended primary school in London and secondary school in Essex. I have positive memories of school and bullying was not something which I personally encountered, yet I recall some incidents of bullying between peers. Prior to clinical training, my main career was as an Offender Manager in the Probation Service, where I worked for 7 years. Working with offenders highlighted the relevance of individual history, family and social context in

shaping experience and behaviour. It also drew my attention to the prevalence of childhood abuse in this population and its impact on adult mental health.

Following an MSc Psychology Conversion Course, I worked within secondary-care adult mental health services as an Assistant Psychologist. Most of my work was with individuals who had experienced complex trauma. However, I had little experience of working with psychosis until my first-year doctoral training placement in a specialist psychosis service.

Clinically I lean towards integrative ways of working, but my background experience leaves me more familiar with cognitive-behavioural approaches. I value psychodynamic and systemic approaches in helping to expand thinking around clinician, patient, family and team interactions. I believe that it is not possible to take a person out of context and therefore support the view that the 'individual' and the 'social' are mutually constitutive (Larkin, Eatough, & Osborn, 2011). I also support the position proposed by Shaw (2010); that we can never fully escape the subjectivity in which we view and interpret the world.

Considering the discussion above in line with ontology and epistemology, I approached this study from a critical realist position. I assumed that there is a reality to be discovered around the phenomenon of bullying but was aware this was complicated and would need to draw on my own knowledge to understand the underlying structures and contextual factors behind it.

Selection of methodology

Guba and Lincoln (1994) explain that methodology asks, 'how can the inquirer go about finding out whatever they believe can be known'? Having considered my epistemological positioning, the most suited methodology was explored. Whilst several

qualitative approaches are available, grounded theory, narrative analysis, thematic analysis, and interpretative phenomenological analysis (IPA) were reviewed as they appear to be most commonly adopted (Biggerstaff, 2012; Javadi & Zarea, 2016).

Grounded Theory

Grounded Theory has a long history in qualitative research, developed by Glaser and Strauss (Glaser, 1978; Charmaz, 2006). They critiqued sociologists for being preoccupied with 'testing' theory and argued that theory should be grounded in qualitative data from concrete local settings (Pidgeon & Henwood, 1997). Due to the focus on theory generation, grounded theory is probably best suited to questions about *processes* and *influencing factors* behind a phenomenon (Braun & Clarke, 2013). In this topic area for example, it might be useful for developing a theory around the factors that influence childhood bullying. One of the distinctive procedures outlined with grounded theory is to not engage with the literature prior to analysis. Whilst helpful in avoiding preconceptions influencing the data, I was inherently aware that I already had immersed myself in the topic literature and worked in the field. I was also focusing on subjective experience rather than theory development. Considering this, a grounded theory approach was not chosen.

Narrative Analysis

A narrative approach places emphasis on the 'story' in shaping lived experience and identity (Murray, 2015) Therefore language is highlighted as being important in possessing emotional intensity. Narrative is considered both a phenomenon and a method (Clandinin & Connelly, 1994). Personal stories are not considered just a description of a person's life, but the means in which they organise their experiences and the information they encounter (Feldman, Bruner, Renderer, & Spitzer, 1990). The focus on the importance of language and individual 'story-telling' lends this to be a useful approach in giving 'voice'

to marginalised populations (Murray, 2015). It was thought that this approach might be useful if the interest was in the stories told by individuals who have experienced a specific type of bullying, such as homophobic or racial bullying. However, given the lack of qualitative research in the field of bullying, along with its complexity of psychosis, it was not chosen.

Thematic Analysis (TA)

Braun and Clarke (2006), define TA as 'a method for identifying themes and patterns of meaning across a dataset in relation to a research question'. One of the main strengths of TA is its flexibility, it can be used to answer a range of research questions and analyse various data sets, using experiential to critical approaches. However, because of the focus on patterns of data across datasets, individual experience and 'voice' can get lost. It also lacks guidance for higher level, more interpretative analysis and lacks interpretative power if not used within theoretical frameworks (Braun & Clarke (2006). Considering these weaknesses, there was concern that this approach may result in wide realist descriptions of participant concerns and miss the subtler nuances within individual accounts that may be pertinent to the role of bullying in psychosis.

Interpretive Phenomenological Approach (IPA)

IPA's overriding concern is exploring lived experiences along with the *meanings* they attach to these; it is therefore concerned with 'persons-in-context' or 'being in the world' (Larkin, Watts & Cliffton, 2006). Research is interested in the experiential world rather than searching for a truth about the structures that underlie these experiences. Willig (2013) uses a useful example to explain this; if a person experiences himself as 'rejected by the whole world', it does not actually matter if he was *really* rejected by all. The aim is to view the world 'through their eyes' and not question the validity of their account. I value

how this approach recognises that the same difficult life event (in this case bullying) might be experienced in several ways.

Moreover, IPA is theoretically rooted in the social cognition paradigm of social psychology (Fiske & Taylor, 1991) and critical realism (Bhaskar, 1978). As such, IPA views the person as a cognitive, linguistic, affective and physical being, assuming connections between what they say and their emotional state. With cognition as a central analytic concern of IPA; there is an interesting theoretical alliance between the approach and the cognitive paradigm. This paradigm is also central to recent theoretical thinking around childhood adversity and psychosis, along with treatment approaches.

In summary, IPA is well suited to the research questions as it aims to give meaning to participants personal and social worlds within a psychological framework (Larkin et al., 2011). The objectives of IPA are to produce not only a coherent third-person, psychologically informed description but to develop a more overt analysis which positions this in relation to wider social cultural and perhaps theoretical context (Smith, Flowers & Larkin, 2009). The interest is upon exploring the 'phenomena' of childhood bullying, within the context of both their environment at the time and their experiences of psychosis. Finally, IPA is useful for exploring concepts with particularly ambiguous definitions and complexity (Braun and Clarke 2006). As has been discussed in the previous chapter, there is large definitional ambiguity and complexity around both bullying and psychosis. As such, and considering my critical realist position, there was considerable rationale for an IPA approach.

Theoretical roots of IPA

Whilst rooted in critical realism, IPA has been influenced by two fundamental philosophical discussions; phenomenology and hermeneutics (Smith et al., 2009).

Phenomenology

This is an area of philosophy concerned with the study of experience; thinking about what it is like to be human. A phenomenologist then does not search for, or make claims about the *causes* of thoughts, feelings or perceptions but is interested in understanding what it is *like* for the person to experience them, as if stepping into their shoes (Smith et al., 2009; Willig, 2013). The founding father of phenomenology was Edmund Husserl (1859-1938) who was particularly interested in reflection of experience and how we might move our attention from every day experience (or 'natural attitude') and focus it inwards, towards our own perceptions of the experience. In this sense, we become conscious of them, hence a 'phenomenon' (Giorgi, 2009).

Husserl suggested using phenomenological reduction to secure a foundation of knowledge, rather than focus on mental directedness of real people. To follow the process of reduction, a researcher should put to one side their own assumptions to truly access the subjective phenomena being explored. Followers of Husserl (e.g. Heidegger, Meleau-Ponty, Schultz) advanced this and moved from a descriptive nature towards a more of an interpretative position (Aspers, 2009). So, rather than suggest a researcher puts aside their assumptions (as Husserl noted), they instead acknowledged people are not in isolation. Therefore experience was considered a lived process in which an individual's unique perspectives and ways of making sense of these are embedded amongst relationships with others and the world (Smith et al., 2009). As a researcher, the aim is to make sense of participants sense-making. This idea of 'sense-making' draws us to the second philosophical discussion, hermeneutics.

Hermeneutics

This is the theory of interpretation. Originating to interpret biblical texts, it developed to a range of literary and historical documents. It is predominantly associated with Heidegger (1962/67) who questioned whether it was possible to uncover an original author's meaning or intention. Schleiermacher (1998), another important hermeneutic theorist, saw interpretation as an art or craft rather than following mechanical rules. He suggests that a writer's techniques and intensions are unique and will therefore impress a meaning upon their own written text. A reader can then uncover this meaning through their intuition and through setting it in the context in which it was originally written. This is useful in a research context in recognising the interplay between researcher and participant.

The weaving of phenomenology and hermeneutics in IPA reflects the way in which when a researcher reads a text, the understanding is a form of dialogue between the old (researchers fore-understanding) and the new (the text itself). Its attempts to get as close as possible to participant experience (phenomenological aspect) which inevitably requires an interpretative effort from the researcher and participant (hermeneutic aspect). Thus, IPA examines *how* the phenomenon appears whilst implicating the researcher in the sense-making of this appearance (Smith et al., 2009).

There is thus a 'double hermeneutic' in IPA research, where the researcher makes sense of the participants sense-making. I wanted to know how people who experience psychosis make sense of their encounters with childhood bullying and whether the systems around them (i.e. school, family, friends) played any part in this experience. I also wanted to know whether, in their opinion, their bullying was relevant to their psychosis experiences. Therefore, the hope was that I, the researcher, could make some sense of the participants' sense-making. My interpretation of these accounts will have been influenced by my own personal experiences and prejudices.

Idiographic Sensibility

The nature of developing an in-depth, detailed analysis of individuals lived experiences is central to IPA. Some argue that it would sufficiently analyse single case studies and in doing so, still make significant contributions to psychological research (Eatough & Smith, 2017). More commonly, IPA is used for small samples, often seeking participants to be 'homogenous' either in sociodemographic terms, or through type of experience. However, others view small sample size as insufficient in contributing to mainstream psychology claiming a lack of sophistication and substance (Parker, 2005). An idiographic analysis sees the participant as expert in the phenomenon and the stages of analysis (outlined later in this chapter), attempt to hold on to the individuality.

Evaluation of IPA

A strength of IPA is there is accessible and detailed guidance (Smith et al., 2009); this is helpful in guiding a novice qualitative researcher through the process. Also. the orientation to psychological concern fits the approach to many areas of applied psychology. Pringle et al. (2011) discussed the IPA approach in relation to contributions to healthcare research; they concluded it offered an 'adaptable and accessible' approach. They also noted that the ability to give such in-depth accounts honoured the individual participants by allowing health care professionals to hear and understand patient experience.

Parker (2005) however, offered critique of IPA urging qualitative researchers to 'beware' of the method. The main criticisms are that the approach doesn't fully acknowledge what is 'inside' depends on what is 'outside' and saw the alliance with psychology as a weakness, not a strength. Giorgi (2010) questions the philosophical roots of IPA, arguing that the phenomenological claims are deficient and hermeneutic claims are superficial. He proposes that a high level of understanding of continental

phenomenological philosophy and scientific research practices would be required for 'proper phenomenological research'. This argues against the suggestion that IPA is suitable for novice researchers.

Limitations of qualitative research are also acknowledged in the broader sense. For example, I am aware that the method will not be able to test theory or predict hypothesis and is limited by small sample sizes. I am not able to make claims about rigour that a quantitative approach might through employing large sample sizes and sophisticated statistical analysis. I also recognise that there is an assumption made in this methodology that the language used by participants will encapsulate individual experience. This suggests a reliance on a participant having a level of articulation that can convey the meaning in their experience. Finally, the participants' view of the researcher might impact their openness, or their choice of information offered in interviews.

Design

Setting

Participants were recruited from three Early Intervention in Psychosis (EIP) services in outer London and one Early Intervention in Psychosis (EIP) pathway in Essex. Interviews were held on the premises of the team from which they were recruited.

Sampling and sample size

IPA rests on the premise that participants have directly experienced the phenomenon, in this case, both bullying and psychosis. Purposive sampling was therefore employed with the aim of generating 'insight and in-depth understanding' rather than 'generalisability'(Patton, 2005). Whilst there are no rules for sample size in qualitative enquiry, a consensus for small sample sizes in IPA has emerged and three to six interviews are considered sufficient for IPA analysis (Braun & Clarke, 2013; Read, Os, Morrison, &

Ross, 2005). It is argued this allows enough depth and avoids the risk of losing interpretative detail required in analysis. Recommended sample size for Clinical Psychology Doctoral programme IPA research is six to eight participants (Turpin et al., 1997). The aim was therefore to recruit eight to twelve participants to allow for the potential of participants dropping-out of the study. The final sample was eight participants.

Inclusion criteria

Due to this being the first identified qualitative study on bullying in a psychosis population and the ambiguity of definitions, there was an argument for inclusivity rather than applying strict exclusion criteria (e.g. based on gender, type or severity of bullying).

Participants needed to be between the ages of 14-35. This was based on the rationale of recruiting those who are closer to the experience of childhood bullying. This was also in line with demographic features of FEP previously discussed (i.e. rare prevalence under 14 years old, marked increase as adolescents, and usually identified in 15-35 age group). Participants could be any patient who accesses the service who perceives themselves to have experienced bullying in childhood. The definition was kept broad so as not to exclude those who may have considered themselves as bullied but not meet formal definition. It was also to allow for definitions of bullying to be explored with participants themselves. Participants needed to be in regular contact (at least fortnightly) with staff in the service. This was so their mental state, capacity to give consent and risk could be well considered.

Exclusion Criteria

Participants were excluded if they were non-English speakers, due to translation costs. They were also excluded if they were deemed unable to give informed consent. Capacity to consent was determined via discussions with their key-worker, based on

relevant principles of the Mental Capacity Act (MCA, 2005). They were excluded if there were any concerns over their mental state in which taking part was considered de-stabilising (e.g. if in crisis). This was determined with their key-worker prior to arranging any meeting. Individuals with drug-induced psychosis were excluded due to potentially different identifying triggers to the development of psychosis. They were also excluded if they had taken part in another research study in the last six months due to ethical concerns of being over researched and related burden.

Materials

The study included a demographics questionnaire, bullying questionnaire, and interview schedule. All materials were developed in consultation with a group of four patients from a specialist psychosis service, aged 16-19 years old. Including patients in research had a moral aim of empowering patients in an expert-dominated area and optimising design, applicability and validity, as proposed by Abma & Broerse, (2010).

Demographics Questionnaire

A demographics questionnaire was completed by all participants to collect data such as age, gender and ethnicity of participants along with an indication of their mental health diagnosis and treatment

Bullying Questionnaire

A brief bullying questionnaire was developed as a tool to facilitate engagement, ground participants in the topic area and encourage participants to think over their experience prior to the full interview (see Appendix D). When discussed as an idea with patients; they fed back that adolescents would appreciate this more structured start to interview as they may lack confidence in responding to broad open questions with a stranger. It also aimed to situate experiences in relevant developmental contexts (primary

vs secondary age group). This allowed an option to consider comparisons between accounts if different developmental stages were reported.

The questionnaire was predominantly informed by a retrospective measure of bullying developed by Schäfer et al (2004), the ‘Retrospective Bullying Questionnaire (RBQ)’. The RBQ was designed to examine long term correlates of victimisation with adult functioning, hence why it is considered most relevant to this study. The RBQ initially focussed on documenting various aspects of the school experience (e.g. type of bullying, frequency, duration) along with noting the specific time point / context where the bullying occurred (primary school, secondary school or work). The RBQ measure itself was too long to include as a tool for this purpose (44 items). It was therefore adapted it in the following ways.

Firstly, any question relating to the adult experiences was removed as they are covered qualitatively. Secondly, the RBQ was repetitive in asking the same set of questions for each context (‘primary school’, ‘secondary school’, ‘work’). This was shortened to asking once about each type of bullying (e.g. verbal, physical, indirect) and selecting contexts in which they had experienced it. Thirdly, ‘Work’ was changed to ‘community’ to reflect the target age group who may not yet be working or had experienced bullying in activity clubs or their neighbourhood. Some of the wording was adapted to be more accessible to adolescents, in line with patient feedback. Finally, some types of bullying (e.g. social isolation, cyberbullying) were added as they had not been considered in the RBQ.

Interview Schedule

A semi-structured interview is considered the best form of qualitative enquiry for IPA (Smith, 2015). The aim is for the participant to discuss *their* experiences and capture *their* language. A schedule was produced to guide the interview (see Appendix E).

The process of designing an interview schedule is intended to be iterative; it was therefore revised several times through consultation with patients, clinical staff, research supervisors. It was also checked by an IPA expert in a training workshop. Smith et al. (2009) outline a suggested sequence for producing an interview schedule. The broad aim of the sequence is to start by questions that allow more descriptive responses to ease participants into the process, and as they become more comfortable invite them to become more analytical. It was this approach that was taken with designing the schedule, starting by how they might define and describe bullying and think of the period of time they first encountered it. Then questions moved to broader descriptions of bullying experience, social context and response of others. Finally, I was interested in their psychosis experiences and whether they considered their bullying to be relevant in any way. However, to reduce the possibility of leading questions in this area, questions aimed to purely open discussions about psychosis and see how they made sense of these experiences.

It was pre-empted that it might be difficult to establish rapport with participants having not previously formed a relationship with them. Patients suggested this might be particularly hard for people who have been bullied as they may worry about talking to new people. To attempt to address this, adequate time was spent before the recorded interview in building rapport, reassuring of the neutral position of the research and showing interest in their views of their experience.

Smith and Osborn (2003) suggest that the researcher must decide how much movement from the original schedule is acceptable but remain conscious of new avenues being invaluable to the study. Following the first interview, which followed the interview schedule closely, I reflected with an IPA expert. I was encouraged to open with the first couple of questions but then just let the participant lead the direction of the interview. This also helps in recognising their position as expert in the process (Brocki & Wearden, 2006).

The remaining questions on the schedule were therefore rarely asked directly in other interviews but held in mind as possible prompts if the participant needed further guidance. This allowed flexibility to enable conversation to flow where the participant wishes, thus giving space for areas that may not have been considered.

Patients suggested using the word ‘meeting’ rather than interview when recruiting for the study. They said this was so that they did not feel they were being judged, as they associated the word with a job interview. Therefore, whilst in this write up the word interview is used for outlining methodology, it was not used with participants.

Procedure

Recruitment

Following ethical approval from the NHS and Essex University (Appendix F), recruitment commenced from the relevant psychosis teams. To reduce any potential undue influence, participants were only approached by Care Coordinators or key staff members from the relevant teams. The study was presented at team meetings within all services, along with provision of participant information sheets (PIS) (Appendix G) and fliers (Appendix H) Although the PIS was checked for language appropriate to the patient group, patients and staff fed back it still felt lengthy and detailed as an introduction to the study. The flier was therefore produced in collaboration with one of the patients from the consultation group. This was used to first introduce the study, with the PIS used for additional detail if they considered taking part.

Care Co-ordinators considered patients who might meet the inclusion criteria and cascaded the flier to them. If the patient expressed an interest in taking part, they were given the PIS and completed a ‘tear-off’ slip containing their name and contact. Potential participants were invited to an information meeting to discuss the study and ask questions.

In the information meeting, the PIS was read aloud and consent was discussed. If the participant still expressed interest, then a date was arranged for the interview to be completed. Participants were informed that their participation would not impact their care or treatment in any way and if they wished to change their mind and cancel the interview then this would also not impact on their care. The recruitment process is summarised in Appendix I, Figure 1.

Data Collection

Interviews were conducted in a contained setting, familiar to participants, namely in the service buildings from which they were recruited. After building rapport, consent forms were completed with participants, reminding of issues such as limits of confidentiality, the audio-recording process and their right to discontinue at any time. The demographics questionnaire was then completed, followed by the bullying questionnaire. The main interview was then conducted. The time allocated was between 45-60 minutes. Following interview, participants were given additional time (10 minutes) as a de-briefing exercise. They were also offered contact numbers for post-interview support and an optional follow-up debrief. Interviews were recorded on a dictation machine. Information was stored according to data protection and confidentiality unless risk factors deemed it necessary to share. Interviews were transcribed verbatim by the researcher and saved in a secure password-protected file. Original interviews were deleted from the dictation machine.

Method of analysis

Smith et al. (2009) described IPA analysis as an iterative and inductive cycle and posit there is no right or wrong way of conducting it, suggesting researchers can be innovative. They outlined stages of analysis which were closely followed in this study:

Step 1: Reading and re-reading This involved immersing myself in the data, first by listening to the recording whilst reading through the transcript and then re-reading the transcript imagining the voice of the participant. This stage aimed to allow the focus to be on the participant and slow down a natural propensity to 'scan' or summarise complex information. This stage also aimed to understand how certain parts of the narrative bind sections of the interview together. It also facilitated thinking about how rapport and trust developed throughout an interview.

Step 2: Initial noting This step examined initial observations of language use and semantic content. The aim of this stage was to produce a detailed set of notes and comments on the data. This stage remained close to the participant description of experience, noting the key things that matter and what these things mean to them. This involved thinking about language and the context of their world. The process of engaging with data in this stage is considered as important as making the written notes on the transcript. To facilitate this process, transcribed interviews were placed on a document with 2 margins, this initial noting occurred in the right margin (See Appendix J)

Step 3: Developing emergent themes This step involved re-reading each transcript but shifting focus to defining themes that emerged in further detail. The process also aimed to attempt to reduce the volume of detail, without losing its complexity. It involved focussing on discrete chunks of data whilst also recalling the initial notes made from previous stages. Emerging themes were noted in the left margin (See Appendix J)

Step 4: Searching for connections across emergent themes This involved finding a way in which to chart, or map connections between themes within the interview. This was done by printing a list of all emergent themes from the interview, cutting them

out and placing them on a large piece of A3 paper. Themes were grouped together or placed apart, depending on whether they reflected similarity or difference.

Step 5: Moving to the next case Steps 1-4 were repeated for the next interview transcript (to maintain individuality). It was noticed that having some knowledge of themes from the previous transcript may have influenced generation of themes emerging from the next transcript. However, individuality was maintained as much as possible. The same process was then repeated in turn, for all other transcripts.

Step 6: Looking for patterns across cases This involved looking for connections across cases, identifying potent themes, thinking about how themes in one case might also illuminate another. This was carried out by cutting out groups of emerging themes for all participants and moving them around on a large table to visually make these connections. This process produced a first draft of the master superordinate and subthemes across the dataset. This draft was then discussed with supervisors and revised until it felt it adequately reflected participant experiences. A first draft of themes was then produced and checked back against each transcript. This was further reviewed and developed with supervisors until the final table of super-ordinate and subordinate themes was reached.

Ethical Issues

Participating in a research project on the experiences of bullying is ethically sensitive. Participants are in a vulnerable position as questions posed may have an emotional effect. This type of vulnerability may lead to a conflict between the aim of the research and the need to respect their integrity. Participants were provided with information prior to the study and given plenty of time to consider participation. The PIS explicitly stated the aims and procedure of the research and the types of questions they would be asked. Participants were interviewed in private rooms to ensure confidentiality

and privacy. All participants were made aware of audio-recording via the PIS and consent form.

During interviews, it was important to carefully observe and be sensitive to any reluctance to discuss difficult experiences and offer adequate opportunities to take a break or stop the interview if necessary. The design of the interview aimed to reduce distress by allowing participants to control the depth in which they describe their experiences. If the participants raised anything of concern, this was passed on to the referring member of staff. These limits to confidentiality were fully explained, prior to signing the consent form.

Considering the potential age group from 14 years old, additional considerations were made in line with ethical discussions around research with children (see Kirk, 2007). It is argued that children should be thought of differently due to their experience of the world being different from adults. Furthermore, the power difference existing between an adult researcher and child participant is greater (Mauthner, 1997). According to the NHS Health Research Authority, it is commonly assumed that the principle of 'Gillick competence' be applied to consent for research with children. This suggests that if a young person has enough understanding and intelligence to consider fully what is proposed, they can give consent to participate. However, the University Ethics Faculty stated that parental consent is required for under 16's. This can be debated as although protective, this could undermine children (in this case teenagers). They may also not have any relationship with a parent, could be denied the opportunity to take part, or feel unable to share personal experience with them present. On the other hand, the parent or carer might take on a coercive role and encourage them to participate even if they are not interested (Harden, Scott, Backett-Milburn, & Jackson, 2000)

The issue of power imbalance needs to be considered when working with vulnerable groups in general, not just with children. Some researchers recommend acknowledgement to participants of the privilege it is to be allowed insight into their lives either verbally or in writing letters of thanks (e.g Finch, 1993). All participants received letters of thanks with the summary of the outcomes of the study.

A further consideration is the dual role of the researcher as a Trainee Clinical Psychologist. I remained aware of being drawn into a clinical role and away from the role of a researcher which may have resulted in a different interpretation on described events. There is also the potential of exposing the researcher to harm if listening to distressing events; supervision was used throughout to discuss any potential issues.

Individuals from different ages, gender, cultural or social backgrounds may assess the implication of harm differently from the researcher, for example language that may cause offense. BPS Ethical Guidelines suggest that the judge of this is drawn from the same population. This was addressed by collaborative design of materials with patients from the same service and same age group.

There are also epistemological considerations that link to ethics. The way that I conceive and recall adolescence might shape the extent to which I consider them to differ from adults, an argument outlined by Punch (2002). Some conceptualise childhood as being another culture rather than a stage towards adulthood (Harden et al., 2000). Others go as far as to argue that adult researchers are unable to understand the view point of a child (Christensen, 2004). Consequently, it may be possible that the interpretations of data of adolescents, actually produces an adult interpretation of their social world (Davis, 1998). Reflexivity in this study has aimed to try and bridge this gap. I also recognise that I may

have forgotten many elements of adolescence and culture changes over time, therefore limiting any 'knowledge' about what that age group might be like for participants.

In summary, the essential principles of ethical research are that it should be conducted paying regard to participants' psychological wellbeing, health, values and dignity (BPS, 2010). Qualitative research has received less criticism from an ethical standpoint, probably due to the assumption that there is a lower chance of posing a significant risk to participants (Richards & Schwartz, 2002).

Assessing quality

It is argued that the constructs of validity and reliability (traditionally associated with quantitative research), are also important when conducting qualitative research (Brink, 1993). Yardley (2000) principles are recommended as the most suited quality guideline in IPA research (Smith et al. 2009). Four main principles are proposed; sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance.

Sensitivity to context considers whether the research is sensitive to the sociocultural milieu, existing literature and data obtained from participants (Yardley, 2000). Choice of an IPA approach represents sensitivity to context by its nature as it requires close idiographic focus on individual experience (Smith et al, 2009). Participants who experienced both bullying and psychosis were considered potentially difficult to access and engage in research. Therefore, a collaborative approach was taken throughout whereby relationships were built from the early stages of design, incorporating patient and clinician views. This was to ensure the design was as sensitive as possible to the participant group. During interviews, the researcher remained aware of potential power dynamics and drew from clinical skills in allowing time to establish rapport, put the participant at ease, showing empathy and respect. These approaches also meet the principle of 'commitment and rigour'

which is demonstrated by in-depth engagement with the topic, thorough data collection and expertise in methods and analysis (Yardley, 2000). The considerable attention paid to participants' narratives in interview, transcriptions completed by the researcher, step-by-step IPA analysis and write up also meet this principle. Additionally, external training and consultation was sought to ensure adherence to the principles and ethos of IPA.

The 'transparency and coherence' principle refers to the research and analysis process being be clear to the reader (Yardley, 2000). The study therefore aimed to be clear in structure, transparent in methodology and inclusive of researcher reflexivity. A reflective log was used throughout (see Appendix K). The 'importance and impact' principle refers to the requirement for research to be useful in practice or how we think about the world (Yarley, 2000). The research is clinically important in the field of psychosis and aims to meet a clear gap identified in the literature. Plans to publish findings and disseminate also aimed to meet this principle.

Dissemination

The research study will be prepared for submission for peer-reviewed journals such as 'Psychosis', 'Schizophrenia Research' or 'Psychosis, Social and Integrative Approaches'. These journals have previously welcomed qualitative research of individual experiences of psychosis. Conferences focusing on psychosis may be interested, such as The International Society for Psychological and Social Approaches to Psychosis (ISPS). Presentations will also be offered to the teams in which the research took place, and to Area Psychology meetings. Dissemination by presentation to school staff has also been planned.

CHAPTER THREE: RESULTS

This chapter presents the findings from an Interpretative Phenomenological Analysis (IPA) of eight individuals. Initially demographic data will be presented, followed by a brief exploration of how participants define the concept of bullying. The final themes derived from their accounts will then be presented, supported by interpretative descriptions of each theme.

Demographics

The sample consisted of 4 males and 4 females. The mean age was 22.1 (SD=4.35; 18-32). Due to the age of the client group and the approach taken within early psychosis services, participants had not all received formal diagnoses. However, according to service criteria, they had all experienced a 'first episode of psychosis'. One participant had a formal diagnosis of schizophrenia, three participants had additional diagnoses of anxiety and one participant had an additional diagnosis of agoraphobia.

Bullying occurred in school contexts for all, with six participants experiencing it in both primary and secondary school. Alec went to school in a Northern-European country, Samuel went to school in Ireland, all others went to UK schools. Bullying occurred at least once a week for all participants. All participants considered their experiences as 'quite serious' or 'extremely serious'. The youngest age bullying occurred was age 5 years old, the oldest was age 16. The mean duration of bullying was 6.4 years (SD = 4.2; 1-12). No participants still experience bullying. All participants were victims of bullying, with one (Theo) adopting the role of both a victim and a bully.

For most participants, the onset of psychosis was between 16-18 years old, after they had left school and bullying had stopped. Two participants experienced psychosis

whilst still in school and when bullying was ongoing. Further demographic information is displayed in Table 1.

Table 1

Participant demographics

Pseudonym	Age	Gender	Ethnicity	Inpatient admissions (days)	Talking therapy (weeks)	Bullying context [1]	Frequency [2]
Hira	18	F	British Asian	1	52	**Primary** Secondary Cyber	Several times a week
Gemma	20	F	White British	0	0	**Primary** **Secondary**	Everyday
Ricky	32	M	White British	2	4	Primary **Secondary** **Community**	Everyday
Alec	24	M	European	21	6	**Primary** Secondary Cyber	Several times a week
Maria	20	F	Black British	0	12	Primary **Secondary** Community	Everyday
Theo	20	M	Black British	0	6	**Primary** Secondary Community	Once a week
Samuel	22	M	Black British	112	52	**Secondary**	Once a week
Farrah	21	F	British Asian	0	8	**Primary**	Everyday

M=male, F=female [1] Indicates location of bullying (in primary school, secondary school, community (neighbourhood), or via cyberbullying). Bold text indicates where this was deemed most serious by participants (for some, seriousness was considered alike across two contexts)_[2] Indicates frequency of the bullying experience considered most serious by participants.

It is sometimes helpful to compare demographics with those in the wider service, to explore whether the sample was representative and add context to the teams from which the sample was recruited. Service demographics were requested but were not able to be provided from all teams. Making such comparisons may also have been contradictory to the phenomenology of an IPA approach. IPA aims to maintain an idiographic focus which, as Smith and Osborn (2003) state, 'goes in the opposite direction of representativeness'. They argue that within IPA, thinking in these terms is not helpful and maintaining focus on a closely defined group for the research question is more useful.

Participant definitions of bullying

The term 'bullying' was explored with participants to consider how they defined it. An intent to harm was included in participant definitions, for example, "emotional or physical harm or pain caused to another person really. Purposely done" (Ricky). Maria's definition stated the various forms it takes, "indirect, or direct attack on someone, whether that is through words or the internet or different ways". Some noted the prolonged, repetitive nature, such as "something that happens every day to the same person, that doesn't stop no matter how hard you try to stop it" (Gemma), or "Bullying is a consistency, it is consistently terrorising or inflicting illness on others" (Theo). Samuel reflected the power imbalance, "People putting you down because they don't see you, they see you as weak or something".

Therefore, the way participants framed the concept of bullying as a 'definition' is consistent with definitions in the literature where hostile intent, imbalance of power and repetition over time were important (Olweus, 1993; Peterson & Rigby, 1999)

Overview of findings

A total of four super-ordinate themes and 15 subordinate-themes emerged from participant accounts. A summary of the theme structure is displayed in Table 2.

Analysis followed the process outlined by Smith et al. (2009). Although IPA allowed a level of immersion in participant accounts that led to a wealth of understanding, the focus here remains on an exploration of the experiences that were mostly pertinent to the research question.

Table 2

Themes emerging from interviews

Superordinate Themes	Subordinate Themes
1. Facing daily threat	*Just kids being kids:* Is it trauma or just school? *Snitches get stitches:* Fearful consequences of telling *I used to skip out on school so often. I used to fake being ill so often:* Finding ways to keep safe *Always on the lookout:* From vigilance to paranoia *A bunch of negative experiences that all had negative outcomes:* An escalation of external threat
2. Overcoming systemic mistrust	*Dealing with the teachers was probably worse than dealing with the actual girls:* The struggle for help *They aren't interested in what's happened to me:* Feeling unheard by services
3. Negotiating power imbalance	*He wanted to be alpha male:* Positioning of bully as powerful, self as weak *Everyone was against me:* Power of the group *There were hierarchies:* Social power – being positioned as different *I felt like I needed to fit in:* Exhausting efforts to belong to the hierarchy
4. A process of evolving identity	*What is so bad about me?* Questioning own worth *I was looking in the mirror hating myself:* Developing an inner bully *They are telling me to be quiet, that I'm worthless, to stop talking to you, to kill myself:* Hearing critical voices *When I took away the label of a mental health issue then I felt I could progress in my life:* Understanding and moving forward

1. Facing Daily Threat

This super-ordinate theme reflects the stories of intense fear intertwined throughout participant accounts. The threats inducing such fear mostly started with bullying in primary

school and continued throughout secondary school. For some, threat escalated through facing additional life stressors. For most, fear remains present in current life, in the form of psychosis experiences.

1.1 *Just kids being kids:* Is it trauma, or just school?

All participants reflected on the origin of their experiences being name-calling, most commonly in primary school. For some participants, this escalated into events of traumatic physical or sexual violence. They believed these were disregarded by the traditional concept of bullying (i.e. being hit, kicked, belongings stolen, name calling). Farrah described this as an assumption of "just kids being kids'. Participants stated that the frequency, seriousness and longevity of their bullying contributed to the intensity of fear they experienced. Throughout participant accounts, there was a strong image of physical and emotional exhaustion from the responses to daily threat:

> It was very frightening, it was almost every day you are worried. Worried all the way into school, at school, until all the way home, so you are getting this, your heart sinks, you panic, and you worry. That should only happen to you in quite serious situations, but I found this was happening to me every day. (Ricky)

Ricky clearly expresses the impact of bullying, but questions whether his responses were warranted, perhaps not considering it a 'serious' situation. However, he also describes:

> One minute we were sat round having a laugh and the next minute I'd woken up, been severely beaten up, to the point where I had blood all over my face, bleeding nose, cheeks. My mobile phone and everything I had on me had been stolen, I was in severe pain. It made the front page of the newspaper actually. (Ricky)

The reference to the publicity of the violent event suggests it was far from a 'normal' part of school life. He later spoke of how post-traumatic stress was suggested by a keyworker but 'never looked into or diagnosed'. Perhaps without this endorsement from others he was

left questioning the validity of his emotional responses. Other participants also described severe incidents under the term bullying. For example, Hira described fearing for her life:

> He would literally threaten to kill me. Like he was *really* aggressive. He had really bad anger problems, erm…he used to get excluded from school a lot as well, for getting into fights, or like breaking the glass in the window or something like that. But because of his anger problems when he did used to threaten to kill me I'd be really really *really* scared. (Hira)

She describes the character of the bully and repeats 'really' to emphasise the intensity. Perhaps she feels the need to justify her level of fear, to be believed, or to make some sense of why he bullied.

Three out of the four female participants reported harm of a sexual nature. They all experienced false sexual rumours being spread and being labelled a 'slut'. For Hira, this was both in person and over social media. Gemma and Maria experienced direct sexual violence:

> It started from about 12. He would be touching me and grabbing me and stuff like that [long pause]. Then in history class he touched me [speaking very quietly, inaudible, tearful]. He eventually attempted to rape me. Others in my class didn't say anything. (Maria)

Her struggle in telling her story reflects the level of distress experienced. Such a serious event happening in class also highlights the lack of response from bystanders, public shame and the lack of control over the context (i.e. in class with those who caused harm). These were issues raised by other participants. Maria tearfully described further sexual violence in which her friend (who she also described as a bully) set her up, "I was forced into a situation unfortunately. I ended up sexually…being raped. It was really difficult" (Maria). She was 13 years old at the time. In addition to the trauma of the rape, it makes sense that Maria went on to have various struggles with interpersonal trust. Her beliefs

around friendships and the unpredictable and inconsistent nature of others became a threat that she continued to face.

Gemma described how the consequences of a sexual assault led her to feeling publicly shamed and humiliated:

> It was basically sexual assault. I was in tears, I mean obviously of course I was in tears, kind of nearly got raped by the boy in the year below me [laughs]... The whole rumour went around the whole entire school the day after, that I got raped. By him. Obviously, he must have told his year, so he's told other people and I had people come up to me in lesson saying 'he only did it as a joke'… like that was not a joke. I'm sorry that was *not* a joke (Gemma)

The incongruence between her description of upset and her laughter when telling the story reflects a need to maintain a defence to such painful emotions. She also describes how others actively approached her to defend the perpetrator, perhaps reflecting his position of status within the school. Gemma went on to describe the impact of returning to school where she knew she would need to face seeing her abuser every day. Such experiences of 'slut-shaming' can be viewed as an aspect of sexism because societal gender roles have defined the way that female victims can become blamed.

1.2 *Snitches get Stitches*: Fearful consequences of telling

All participants expressed the main reason they felt unable to tell anyone about their experience of bullying was due to the consequences they believed they would face if they were to tell. For example, when describing the option of telling Theo recalled, "If you are getting bullied you worry you are seen as a snitch or something like that…It's hard though because you can also get bullied more because you are going to be seen as a snitch" (Theo). The fear of the bullying worsening was common for many participants, "You knew it would only get worse" (Gemma), "you'd get bullied more" (Samuel). Others received direct threats. For example:

> [imitating bully] 'If you tell your sister, I'm going to get my brother on you' That was another thing, 'God, I'm not telling anyone'. Her brother was known to be very rough as well (Farrah)

> …he [bully] would threaten me like 'don't tell'. He would go and say to me don't tell, that he would carry on and make it worse. (Hira)

When considering consequences of telling, some participants realised that even a bully school exclusion would not guarantee safety. Hira recalled, "the fact he used to threaten to kill me I thought if he gets excluded, I thought he might see me by myself one day walking around and he might just hurt me then". Similarly, Gemma described "if someone got excluded for bullying, they would tell their mates they got excluded because of me". This then led to bullying becoming more severe.

Ricky recalled an experience of being labelled a 'grass' and believed that this gave bullies further licence to torment. He said, "it was like 'you dobbed me in, so I want to get you back'". It seemed to become accepted that participants just didn't have help as an option. Alec described this within the context of school culture:

> That's the worst thing, worst ever basically. In school there are prison rules….'snitches get stitches', that's the worst thing. Rule number one, don't bat a snitch down because you know it will just get worse. Your parents and everyone can't be by your side 24-7, that's the scariest thing. It will just get worse, so you soon learn you have no way to stop it by telling. (Alec)

Alec, like other participants, stated the threat of telling was the 'worst' thing about his experience. His reference to 'prison rules' suggests his experience of being silenced in such a way is akin to feelings of being trapped and powerless, like a prisoner. He also refers to a need for '24-7' protection, further highlighting a permanency to his experiences.

The sense of powerlessness was shared by all participants, learning that they had no control over changing their circumstances. In the few attempts to tell, participants situations

worsened, quickly dispelling any previous hope that bullying might be resolved. Participant narratives expressed a sense of helplessness, hopelessness and injustice. With the threat of telling so high for all participants, it seems they weighed up the risks and believed that the only option left appeared to be to suffer in silence. Hira reflected on the negative impact of this:

> It made me feel really really anxious actually, erm very scared, I felt like I was keeping everything to myself, it wasn't really good for me, it wasn't good for me at all [long pause] I don't know how to explain it, I don't know how else to explain it. (Hira)

Struggling to put words to her experience mirrors the silencing that she experienced from the threats of others. Later she explained "I started self-harming as well because I became really depressed". Several other participants also reported self-harm and having considered suicide either at the time of their bullying experiences or in subsequent years. This reflects how suffering in silence led to a need to internalise their emotions. Farrah described:

> …I remember being probably in year eight, having that, it was the first feeling of where it just got worse, and where I attempted to take my own life. But even then, I still never went to talk to anyone about it. I never spoke to a teacher, I never spoke to a doctor, I never spoke to any of my friends about it (Farrah)

Farrah's bullying experiences occurred within primary school only; therefore, this extract demonstrates how her distress and fear of telling others continued into secondary school even after bullying ended. Even at her lowest point, she still felt unable to tell anyone. She later described also planning to end her life before her 21st and recalled "…without telling any of my friends. Without even informing the university or talking to my family. It was just a plan. I just thought, 'Okay, I've always felt this emptiness, loneliness as long as I can remember. It's never going to be finished. It's never going to go. The only way to cope with

it is if I go'. This suggests that her early concerns of telling, loneliness and feelings of hopelessness about change, persisted for many years after bullying stopped.

1.3 *I used to skip out on school so often. I used to fake being ill so often:* Developing ways to keep safe

With the risk of seeking help so high, participants were often left with little other option than to develop individual strategies to survive; these appeared to be helpful in keeping them safe from bullies. On the other hand, such strategies exacerbated their feelings of loneliness and possibly taught them that they could not cope in any other way, potentially contributing to increasing feelings of vulnerability and losing self-esteem.

Maria, Hira, Gemma and Farrah talked about trying to find some respite in the toilets. For Hira this break was often short-lived as she recalls being interrupted by teachers requesting her to 'go back in to class'. Maria describes her attempts to face the situation before finding safety in the toilets:

> Every day I would go into the toilets and cry. Before I went to school, I would pretend I was going to lessons but I would get so shaken up I couldn't go into the classrooms, so I would go to the toilets. I would just go and hide and take tablets before I went to school. Strong medication and things like that to deal with it, I didn't know what else to do. (Maria)

Maria uses the phrase 'pretend I was going' rather than 'planned to go' when describing her attempts to join lessons. This may reflect her having already developed a belief that she would be unable to cope, therefore needing to put on a pretence to others that she was going to school, as this was expected of her. Strong medication also acted as a coping mechanism, perhaps a strategy that enabled avoidance by cutting off any difficult 'feeling'. Participants also described strategies to avoid people on journeys to and from school, suggesting these were times they felt particularly vulnerable. For example, Ricky stated "I would wait 20 mins before I walked home or go a different way".

Participants also described feigning illness as a way of trying to avoid school altogether. For Gemma and Farrah this was usually successful and resulted in them missing a lot of their education. Farrah recalled:

> I used to skip out on school so often. I used to fake being ill so often. I just really hated it. I just really hated everything. I hated everyone. I hated anything around me (Farrah)

This extract demonstrates how her feelings of hatred were so unbearable that she was unable to face people and things around her. Her home offered her some respite from these uncomfortable feelings of hatred. Hira's attempts to feign illness were less successful, she recalled "My parents like never ever let me take a day off…like ever…unless I was seriously really ill, I'd always have to go in". This highlights her parents expectations for her to succeed and the additional pressures that she, and other participants had whilst managing bullying.

Some participants recalled how planning their avoidance strategies took priority over work, Ricky said "you are more thinking about ways to avoid things like that, than doing normal schoolwork.". Maria recalled "A lot of people asked, 'Why I couldn't focus, why can't you focus, on work and stuff?'". This perhaps demonstrates the struggle of tackling cognitive tasks when their threat system was so active.

Several participants described avoidance leading on to withdrawing from others and isolating themselves. Ricky explained how his avoidance strategy developed over a period of years:

> I changed in that, I wouldn't go out as much, I wouldn't want to go out, I was home a lot, it was safer. It just used to be a bit of a panic, it definitely used to be a worry…some of the symptoms of agoraphobia are similar to the fear I used to get when I saw these big groups of people. That was like a fear of being outside, a fear of being around people (Ricky)

The feelings of safety at home are described in stark contrast to his uncomfortable feelings

of panic. He reflects on his current experience of agoraphobia and draws comparison of his 'symptoms' with his earlier physical sensations of fear. He also gave an example of using alcohol as a way of coping with his fears of being outside. He recalled:

> I had to be drunk to get outside. Because when I was outside I felt like I was the centre of attention I felt like everyone was looking at me, saying things about me or I was being watched from every angle (Ricky)

Alcohol therefore acted as a strategy of avoiding the uncomfortable feelings of being watched. In this extract, he is recalling experiences around the age of 18/19 years old, several years after bullying had ended. This is an example of how the fear induced from bullying continued into adulthood, a view also expressed by other participants.

1.4 *Always on the lookout*: From vigilance to paranoia

In addition to avoidance, all participants talked of various ways they became more vigilant of their surroundings in school. Participants described this soon becoming a 'paranoid' feeling, this was while bullying was still happening. Paranoia worsened over time and started to appear in other areas of life (e.g. college, work, socially). All participants experienced paranoia as part of their current psychosis, and most had made sense of these in the context of their bullying history.

Participants' initial vigilance was demonstrated by intense questioning processes, creating further anxiety. For example, Hira described constantly thinking about "What if?" scenarios e.g. "What if I bump into him? "What if he sees me?". Gemma talked of being "always on the lookout" for who might choose to bully her that day. Farrah's main concern was peer-rejection so if she saw peers talking, she would think "she's going to tell her something bad about me".

Participants described how feelings of anxiety associated with this questioning continued to develop and remained present. Samuel reflected a continued fear of

humiliation, “I’m always worried about situations. I also think I might get laughed at or something again”. Gemma stated, “I had anxiety about it all through secondary school, I still have that same panic and anxiety now…. I’m still scared of bumping into him [bully]”. Ricky, Alec and Farrah described direct connections between their psychosis experiences and school bullying:

> “it’s paranoia like to do with maybe someone is watching me or watching me through my phone, or people are laughing at me I guess, or are following me [referring to current experience]. A lot of paranoia was to do with people like looking at me and laughing at me and watching what I was doing and things like that [referring back to school]” [Farrah]

She noticed her current beliefs of being ‘watched’ mirrored feelings she experienced from bullying. She also felt she was being watched through her phone (something she carries everywhere). This perhaps reflects an experience that is always present and hard to escape, like when she was bullied. Alec described:

> This [bullying] is where I got my paranoia from because I used to walk back home, it was around 4- miles. I didn’t have a car because I was young, I used to always look over my shoulder like every 10-15 minutes to check if no one was following me. I was really paranoid because my safe-haven was my home and if someone would get into my home then I would have nowhere to run …. I would look out the windows, even though I was far into the countryside I would still look out of my windows to the plains to see who was there and if anyone was coming. (Alec)

Alec expresses conflicting thoughts about his home. Although describing it as a ‘safe-haven’, he refers to potential intruders suggesting he is unable to escape fear. He described the impact this has on his life now, “It’s a constant battle to me every day. Like a bus is waiting, I’m thinking maybe it is waiting for me”. The terms ‘battle’ and ‘fighting’ reflect how his current struggle echoes his previous ‘battle’ with bullies. These examples perhaps demonstrate how strategies that may have helped participants in the past feel prepared for bullies, remain present and have become highly debilitating.

Maria was the only participant who did not use the terms ‘paranoia’ or ‘psychosis’ when describing her experiences. In her descriptions, the experience was very current. She described, “…there was a guy who was visiting my garden when I was 14 and he was listening in on me…he would sit in the garden sometimes and talk about me”. Throughout the interview she continued to speak about these neighbours still listening in on her, following her and listening for her secrets. She also held a belief that people were being sent to her house to ‘expose her’. She described the impact:

> It doesn’t stop, it gets me down, but no one understands or really knows how it affects me…like getting on the bus here, I had to take time to be able to build up to doing it as I know they will be talking about me and there are lots of people around watching me, they are at home but they still follow me when I go places (Maria)

It makes sense that she did not use terminology of ‘paranoia’ or ‘psychosis’ as they both imply experiences that are out of touch with reality. However, for Maria, this was her reality. Such experiences may be framed by professionals as ‘delusional beliefs’. This shows how clinical terms, assigned by professionals and endorsed by society to encompass knowledge around unusual experiences, can differ from how the individual experiences it. The extract creates imagery of exhaustion, complete deflation and a strong desire to feel validated and understood.

Although Maria had not made explicit links herself, her current experiences of being listened to or watched could be understood in the context of her bullying history. It is possible that her sense of still being in danger, fears of ‘secrets’ and ‘being exposed’ are underpinned by feelings of guilt or shame expressed in her sexual bullying experiences.

1.5 *A bunch of negative experiences that all had negative outcomes:* An escalation of external threats

This subordinate theme reflects various life events, in addition to bullying, that acted as further threats for several participants (Hira, Gemma, Ricky, Theo and Alec).

Other participants (Maria, Samuel and Farrah) did not describe any additional life events in their accounts. Bullying seemed to be the primary threat expressed by participants; Hira explained "I think that's when I started feeling quite anxious about things". Other accumulating events added to the threats already faced through bullying experiences. Ricky explained this journey:

> It [psychosis] came from a bunch of experiences that all had negative outcomes. When I was at school being bullied I developed these constant negative experiences of paranoia which then become part of real life outside of school, being paranoid in big groups. Then towards the end of school there was a social change, change in personalities, talking to different people…I still suffered with the anxieties of people. A couple of years after moving away, back, hanging out with friends, falling out with friends, not doing well at college, problems with my dad and family and brother at home. I was dealing with all that happening at the same time (Ricky)

This extract gives a sense of feeling totally overwhelmed and insecure with friendships, education, living arrangements, and family. Gemma also expressed facing several life stressors in school stating, "…with my mental health it all triggered it off". She described the additional threats of, "my dad being ill, three people passing away, my parents splitting up…ended up being ill and having two operations".

Theo also experienced significant loss, he stated "I started listening to depressing music because my mum did die when I was 11 so it was weird". Perhaps reflecting on his emotions by referring to music genre and the term 'weird' felt safer than locating such difficult feelings within himself; his mum died in a sudden car accident. Reflecting on the additional events leading up to his experiences of psychosis he stated "my dad wasn't a good dad. Loads of things, not just one factor in my life…I didn't feel like I had a mental health issue when I was growing up". This suggests he views life experiences as relevant in the development of his psychosis. Alec also lost a parent during secondary school, he described an impact on coping "I was able to deal with it [bullying] as my father was still alive". Losing him left him more vulnerable to the

impact of bullying; perhaps he offered a sense of safety that couldn't be achieved elsewhere.

Most participants described their psychosis experiences starting 1-2 years after school, with two participants experiencing it whilst still in school. They all spoke of how 'frightening', 'scary' and 'terrifying' psychosis was. For example, Farrah described:

> You just want to disconnect and if I could reach in and rip my brain out, that's how I used to feel...It's scary and it feels like being, again, you feel like you're being outnumbered and being hurt and nothing you can do about it or no one in this world can do about it (Farrah)

This powerful image of "ripping her brain out" expresses how painful and desperate she was to rid herself of the experience. With the word 'again' she reflects and compares the emotional experience of psychosis with bullying; feeling outnumbered, hurt and helpless. It makes sense that repeated experiences of similar themes can intensify the emotional impact. She also expressed "You're having a war with yourself every single day you wake up. Every waking day", suggesting the previous war with bullies is now internalised within herself.

Participants also expressed how fear of psychosis is ongoing, for example Hira states "I was living in fear that it would come back, I was going about my day thinking 'oh God what if it comes back?', even to this day now". Her expressions of 'living in fear' have striking similarities to her narratives around bullying.

Ricky described psychosis as "An experience which sort of grabs hold of your life, turns you upside down, empties everything out and says right, now you've got to get on". This powerful expression highlights how psychosis led to total emptiness and yet an expectation that he could just continue regardless of having faced so much adversity and threat.

2. Overcoming Systemic Mistrust

This super-ordinate theme reflects the relationship the participants had with adults from whom they sought, and may continue to seek, help. All participants talked about unhelpful interactions with professionals which left them feeling mistrustful of others. This started in school for most participants, which is reflected in the first subordinate theme. As Alec stated, “Even at school it’s about learning how to play with politics from a young age and with politics there is nothing good in it”. Drawing links with politics, he compares his concern that schools have their own agenda, and individuals needs seemed to get lost in this process. Participants discussed the impact this had on future help-seeking.

The second subordinate theme reflects the participants initial struggle to receive the help they hoped for from psychosis services and how bullying experiences can be missed in these contexts.

2.1 *Dealing with the teachers was probably worse than dealing with the actual girls:* The struggle for help

Five participants expressed poor responses from teachers or school in addressing bullying. Two participants (Ricky and Samuel) never thought to include school as they presumed it would be hopeless. Ricky explained, “It is hard when things just don't ever get done anyway and so you just think ‘Why bother?’...it's much easier to just avoid and keep myself safe”. On reflection, Samuel expressed regret for not telling as he encouraged others being bullied to seek help. He stated, “tell someone, tell a teacher…teachers really should intervene more in bullying”. Theo did not mention school response at all in his account.

For those who sought help, either no action was taken, the bullying worsened, or they were left feeling blamed. During her account, Gemma described an accident where she fell in the playground and broke her nose. She stated, “my teachers, they just patched

my nose, because my nose was bleeding, they just patched it up and sent me back to class". This description acts as a metaphor for how she, and other participants, described their help-seeking:

> When I think about them now, dealing with the teachers was probably worse than dealing with the actual girls. You are told, "Come and tell us if you're being bullied," but when I do, you're not taken seriously, or you're not being believed. (Farrah)

To align professionals as worse than those who bullied shows how desperate she was to be listened to and how devastating it was to not feel believed. She expresses total defeat and hopelessness. This feeling was shared by most participants. Hira recalled "she [teacher] was in a mood at me…she just didn't understand". No action was taken, and the situation worsened. Maria stated "With the situation with sexual harassment in school I was told 'that's just what boys do, and you just have to ignore it. Yeah." Therefore, distressing gendered violence was also normalised and consequently maintained by teacher neglect.

Hira recalled "I just decided not to try again, and I just left it at that.". Similarly, Gemma said "I'm not gonna bother telling the teachers anymore because they are clearly not doing anything". For several participants, the first person they told about their bullying was instrumental in how they approached future help-seeking. Hira considered the difference this might have made for her in the long term, "I was scared, but I feel like if someone actually helped me, if my teacher actually listened to me I think it would've been very beneficial, like really beneficial". Alec recalled his school taking an extreme approach:

> They made it too official. He had to apologise to me in front of the whole class and I just cried like a little baby, it was frustrating. They wanted to show 'ooo we're fighting bullying on a huge scale'…I didn't want that. Nobody asked what I wanted. They just did that, and I got even more humiliated in the end" (Alec)

By taking a stance against bullying the school were trying to help; unwittingly they had instead created a situation of further humiliation. He mocks the school response, perhaps reflecting how he felt mocked. The phrase 'crying like a little baby' expresses his vulnerability. He stressed how his needs were never considered and the needs of the school were prioritised.

Farrah described how a teacher turned to accuse her of being the bully and labelled her as a trouble-maker in school:

> You know that you haven't done anything, but you still think there's something wrong with you…You're at a young age so you, obviously, it's a young age where you take what adults say as the absolute truth, and I took it as the absolute truth (Farrah).

She reflects the conflict between knowing she hadn't done anything but also doubting herself, drawing reference to the value placed on adult opinions through a young child's lens. Once this was acknowledged as 'absolute truth' from an authoritarian other, she saw herself as flawed. She recalled the impact on future trust and how this "stays with you" by stating "I remember specifically thinking I can't trust anyone. I felt, 'Oh my God if she thinks I'm a bully. I *definitely* can't tell anyone anything'." In addition to individual teacher neglect, the broader accounts from participants highlight the challenges within their school systems where bullying policies existed but appeared to be tokenistic and held little value in reality.

Most participants did not consider telling their parents about being bullied. This was true both for parents who were described as supportive and more distant. Hira explained "I knew if I told my parents that they would just tell the school". Only Gemma actively sought help from a parent, yet when the school remained unhelpful, she gave up trying. Parents seemed to only become involved once participants had reached a crisis

point with their mental health experiences and 'as a last resort'. Others relied on friends, siblings or cousins, mainly as they offered the protection they couldn't elicit from school.

In addition to presuming that involving the school would be hopeless, Samuel explained further reasons for not telling teachers:

> I just didn't want to talk about stuff like that [bullying] because people would have started viewing me in a certain way. *What way do you think they could have viewed you?* How they going to view me? Like weak or something like that (Samuel)

His perception of weakness by seeking help may be explained by the threat of emasculation. Theo also described this by stating, "It's hard when you are a guy as well, no one likes a weak man".

It seems all these processes taught them that others, (particularly those in authority) could not be trusted and could not protect them. A belief that continued throughout their accounts. It is possible that early relationships to systems of help may have contributed to a continued struggle to ask professionals for support. For example, Farrah stated:

> Even now to this day I just feel like there is always a trust issue. If I have an issue, I will probably take the longest time if I do even come around to telling anyone that there's a problem. If I think there's something wrong, I still panic, and I still have that same panic that I had when I was younger about I've done something wrong. I haven't done anything wrong, but you still get it. You're still like, "I've done something wrong. I'm going to get told off for it." I think that stays with you (Farrah)

Experiences of mistrust and feeling blamed are therefore long lasting and have an impact on how individuals may access services. All participants described waiting a long time before seeking any help for their experiences of mental health with most journeys into services resulting after someone 'found out', or it hit 'crisis point'.

Ricky expresses regret about this on reflection, "I wish I had gone to a crisis team, the first week when I noticed things aren't right. I didn't, I waited years". Also, he attributed his decline in mental health to further issues of mistrust of professionals at university after he believed his grades were incorrect and he was called a liar. He recalled, "Being treated like that in a system that then makes you angry, makes you ill. You develop a negative view, you lose all the trust of things". This highlights how influential systems can be in contributing to negative experiences.

2.2 *They aren't interested in what's happened to me*: Feeling unheard by services

This subordinate theme refers to the participants view that sharing their bullying experiences is helpful but feeling that there weren't many opportunities to do this, especially early in treatment. Farrah stated, "initially I don't think the help from services was very good". For some it remained an ongoing concern, others reported improved care over time as they engaged with new professionals or specialist psychosis services. Medication was dominant in participant narratives of initial treatment whereas many had hoped for opportunities to talk about their experiences. For example:

> …they [crisis team] wanted to put me on medication and things like that but at the time I didn't really want to do it…I was quite against taking pharmaceuticals as I didn't think that would help. You hear a lot of things about medication like it gives you depression, I just wasn't ready for those things (Ricky)

Because Ricky did not feel his needs would be met through medication, he then continued to try to cope alone for several years until he was eventually hospitalised after experiencing a psychotic episode. This expresses how services can continue to miss those in need if only one method of treatment is offered. Other participants also described how they did not feel medication would help. For example:

> First, I had [name], that was just bare drugs that just fucked my head up, medication off my head like the old school medical stuff…I felt like people were giving me medication and just telling me to wait until I'm better, I was like 'when am I going to get better?', I am just suffering. Then one day someone was more interested, more about my life. It took one hour. (Samuel)

This extract refers to the period when Samuel entered community services after being discharged from an inpatient unit. It expresses the hopeless view of the future that Samuel experienced until he was offered an opportunity to talk about his life, including the impact of bullying on his mental health. He refers to medication as 'old-school' as if this treatment seems outdated in a modern world. His expression of suffering mirrors the experiences that he and others described around bullying; just waiting until it got better whilst the systems around them were seen to have control over the situation. 'It took one hour' implies resentment towards services; talking about his life took such a short time but had not previously been done. Most other participants also expressed wanting to discuss their bullying history. For example, Maria explained:

> I think bullying might have something to do with how I feel now but I am not sure. No-one has ever explained it. No-one I speak to can hear, no one here definitely, they aren't interested in what's happened to me (Maria)

This extract suggests Maria wants to make sense of her psychosis experiences, feeling that bullying played a role but staff haven't explored it. This was surprising considering she reported to have had three months of CBT-P. Considering her history of feeling unheard, not believed or blamed in school, perhaps she struggles to feel that anyone would be interested and has therefore not felt able to share the extent of her experience with her clinician. Alternatively, the therapy may have focussed on present concerns and not asked about historical influences to experience. Farrah was also accessing therapy and explained that bullying is just 'not thought about' or difficult to raise. She stated:

> I guess to a lot of people it's a sensitive topic. People are scared to talk about it. We talk about it, but we don't talk about the experiences of it as well as we should do and the after-effects. That's the main thing…how it's impacted us later on, or how you've dealt with it. I think it's a big thing especially within here [psychosis service], it's a big thing to talk about because I can say now that bullying has played a big role in my mental health and I still haven't really spoken about it within the service or to anyone really…It's always been a, like in a questionnaire 'have you ever been bullied? Yes, but it's never then been touched upon really. That's probably the only time I've been asked. (Farrah)

This extract highlights various systemic issues that other participants also described. Firstly, how staff are perceived to either hold anxieties about discussing bullying or appear to be disinterested. Secondly, how the impact and ways of coping are missed by professionals, even when patients might consider it as playing a big role in their mental health. Finally, it draws attention to the issue of how services incorporate questionnaires about experience, yet these can feel totally meaningless to service-users when conversations do not follow the responses.

The desire to talk about experience was also noticed in the positive response participants had to the research interview. For example, Gemma, who also had never previously spoken about her experiences said "I just think that what you're doing is actually really good. It's actually really good, like kind of I feel relief, relieved, I feel relief now".

3. Negotiating power imbalance

This superordinate theme reflects the various power relationships that played a part in participants' experiences. These presented early in school through interactions with powerful individual bullies or powerful groups. These power systems operated within strong contextual frameworks where a social hierarchy defined people's ability to belong

or face rejection. The nature of these more powerful forces left participants feeling weak and vulnerable and positioned as different to others. This led them to go to extensive efforts to find a place within this hierarchy.

3.1 *He wanted to be alpha male*: Positioning of bully as powerful, self as weak

All participants positioned their bullies as powerful figures, holding status and admiration from others. On the other hand, they referred to themselves as 'weak', 'small', 'younger' or 'disliked'. Alec recalled, "He was really aggressive, in some sense he wanted to show his dominance, so he never wanted to be humiliated or be less of a person, he wanted to be alpha male". Maria spoke of the motivation of the bullies as "a psychological thing to weaken me". Furthermore, Samuel suggested, "if you're seen as weak you're going to get bullied more." The power imbalance is also referred to by Alec using a metaphor of a video game:

> It's like in a video game if you are fighting with another player you need to use the same equipment that they are using to defeat them. In some sense, if you have lower equipment or using different weapons that they are resistant to then it's just not going to work (Alec)

Most participants described bullies as 'looked up to' by others. In contrast, Theo described being disliked when he was in the role of the bully, "no one liked me at that time, I was kind of, people were scared of me". He explained he became a bully, partly to protect himself from being bullied and partly due to experiencing a lot of anger from the loss of his mother.

Some participants tried to make sense of the bullies' behaviours, questioning whether they may be projecting some of their own difficulties:

> I was getting beats for no reason, to toughen me up. I was like, I don't need that, I'm just trying to be myself and I'm just trying to go to school,

> have fun and you're just projecting your stuff on me, I don't get it. (Samuel)

Gemma stated "they [the bully] don't know how to stand up for themselves, so they just let out, and do what they think is right. For them it seems right. For them it seems like a relief". She therefore understood their strive for dominance as a way of diverting from their own feelings of weakness, perhaps a relief from uncomfortable feelings of vulnerability.

Many participants talked about ways they tried to regain power over time, by starting to defend themselves, or developing resilience. Alec made a conscious decision to build up his own strength:

> I'm going to the gym for my protection because they wouldn't even dare say something about me in front of my face. It's my coping mechanism in some sense as well (Alec)

Although the bullying had occurred several years previously and in a different country, he talks here in the present tense. This suggests he still defends against his sense of powerlessness by preparing himself for potential future threats. He also reflects on the gym having a dual purpose of being a coping tool. He stated, "It's easier to have better scars and bleed than just sit and wallow in my pain every day". The word 'wallow' represents an image of being stuck in mud, powerless, unable to set himself free.

Hira and Alec described cyberbullying as being much easier to bear than face-to-face bullying. They were the only participants to have experienced bullying via these methods. Although they expressed some feelings of humiliation, they had the control and therefore power over being able to stop it, whereas in school they did not. Hira said, "when it's on Facebook I'm able to block him, like I can block you from my page".

3.2 Power of the group

For some participants, the sense of powerlessness came from being bullied by a group. Several participants described this happening in a process, a contagion of bullying from one to another. Several participants also recalled bystanders who ignored or joined in bullying. For example, Hira said, “no one would actually directly go up to him [bully] and be like ‘stop doing that’”. Gemma recalled “they made new mates and they told their new mates about me so then they ended up bullying me, so it was like ‘ok…so now you have got your little squad that can bully me now”. Farrah described a progression of losing friends to the bully:

> What happened was it progressed into, obviously, she didn't like me initially and she took away my best friend then and eventually it was just like everyone was against me. I just felt like the loneliest little girl in the world. I just thought no one likes me. I have no friends. I remember sitting out at playtime on the bench, it was cold and freezing, by myself and watching them play in the distance. (Farrah)

Feeling like the ‘loneliest little girl’, positions her as small in comparison to a more powerful ‘everyone’. Her description of ‘cold and freezing’ may represent her struggle to find any warmth in her peers. The extract brings an image of her sitting alone on the bench with so much sadness. Her description of ‘watching them play’ suggests a longing to be part of their group, yet this being so distant from anything she could imagine being part of.

Ricky described how there was a power imbalance between sub-cultures, recalling “We’d get dressed up quite strongly, have chokers and things like that. We were quite an easy target for some people. It did cause quite a lot of paranoia and fear.” Whilst they weren’t afraid to show their identity, this also placed them in a vulnerable position and led to further fearful responses. He also described how groups formed with a clear intention to target others:

> "Friends of friends or those friends of older people who'd left school or were in the older years actually sort of I don't know what they called themselves, but they were like greebobashers. They deliberately went around picking on people who were alternative (Ricky)

3.3 *There were hierarchies:* Social Power

Most participants recalled the context of their childhood being based around a network of social hierarchies. Those with greater social power were usually referred to as the "popular", "trendy" or "cool" group:

> "They thought they were superior to everyone else because of the amount of friends that they had. Or the amount of likes that they got on their Facebook pictures. Or just things like that, the trainers or clothes they would wear, the pictures they would take of themselves, their selfies and stuff, or how much they went out, how much they went to the shopping centre, things like that. That's what kind of defined them" (Hira)

Hira describes how 'superiority' was defined by material items and self-image; societal influences continuing to reinforce an image of an 'ideal self'. Those who match up to this view could be considered more desirable and therefore achieving more friendships. Considering these factors, participants from families with a lower socio-economic status and therefore less access to resources, were already placed in a position of disadvantage. Alec described how relevant this was, "They [classmates] were living in town, their parents had more income and I was lower *lower* class. The class division from a young age was important."

Physical attractiveness was also described as superior by several participants and allowed access to the more powerful group. Maria expressed envy towards a childhood friend who "was good looking so got a lot of attention, had a lot, a lot of friends" and so was accepted in a clique whereas Maria was "thought to be the not so intelligent person".

It was most common for bullies to be identified with the groups holding greater social power. Theo described how he managed to join the 'cool kids' by bullying the 'weird' kid.

> "Because there was this kid he was kind of weird, so the cool kids would make fun of him and I would copy to fit in, that's about it. They would dare me to do stuff to him like kick him and stuff. Sometimes I would and sometimes I wouldn't. It was fucked up, it was weird. I don't like beating up other people. It's like, I don't like it. I don't know what the guy does now, what he is up to." (Theo)

On reflection, Theo describes a cognitive dissonance between his actions and his values suggesting the desire to belong to the more powerful group was strong. He wonders what the victim is doing now, perhaps reflecting on the impact of bullying from a more adult lens and questioning if his actions had a long-term impact on the victim. He went on to emphasise the power imbalance and perhaps justify his actions he now feels shameful about "It's just the way it is in school, you need to fit in to survive, you bully, or you are bullied so I had to choose the stronger way".

The impact of social power on bullying experience was evident as all participants spoke of name-calling from a more socially powerful group or individual. Participants were predominantly targeted for their difference, expelling them to a marginalised out-group. This expulsion usually centred on appearance, race, intelligence, religion, or social group. Terms used to describe the feelings this evoked were 'alienated', 'rejected', and 'isolated'. For example:

> First of all, I was quite chubby so that was a thing; the second thing is that I was from the countryside. They were saying that I was uneducated, filthy and so on. Because of my ginger hair I was also bullied because of that, my hair was in my way all the time. In my country they say, if I had to choose to be burnt alive or to be born ginger, they would say they would rather be burnt alive. They are so harsh about it (Alec)

This extract gives insight into the discourses within European society about being from the countryside and having ginger hair; also, the extent to which he may have internalised these stereotypes. This is demonstrated in the comparison Alec made about preferring a painful death to being ginger.

Three participants experienced racism. Maria explained that being black and well-spoken ('prestige speech') left her rejected by both black and white people:

> I never really quite fit in with any people…maybe…. unfortunately. They also called me Oreo, because I looked black on the outside, but I acted white. So, I couldn't win either way. Black people didn't like me for being too white and white people didn't like me for being too black (Maria)

This highlights how others had positioned her in relation to whiteness, drawing from a narrative inherited from history where white people are thought of as civilised and superior. She expressed struggling to integrate parts of her identity using the example of not fitting in with different ethnic groups in which she was always 'different'. This provides an example of where whiteness is used to reinforce racial inequality.

Theo and Samuel were also was racially bullied. Theo stated, "He [bully] used to follow me, and he called me a black cunt and I just couldn't take it anymore, so I hit him in the face. That's really it". He therefore regained power by retaliating. His response was blunted and sharp, perhaps reflecting a sense of apathy when talking about these experiences. When discussing the impact of racial bullying, Samuel separated his school-home life, "I only felt like that when I was at school but when I left school I forgot about it, that's the type of mentality I had so". Samuel was part of a wide black community outside of school. Perhaps this separation was possible as he achieved a sense of belonging and safety elsewhere.

Seven participants described their bullying experience ending because of social changes in their environment (i.e. leading to difference being accepted within the hierarchy), rather than any action taken by them, or others. Therefore, from participant perspectives, it was only the changes in social hierarchies and context that led to the end of bullying. This reflects how powerful the social context was in shaping their experiences. For example, Alec said, "I went to college and people are way more educated way more tolerant, way more grown up and everything changed then". Farah recalled more acceptance in university cultures, "You just let go of things, whereas in school culture, everything you're doing is more scrutinized". Ricky recalled:

> "As it got into the last years, some people started changing their attitudes towards other people. Not necessarily the bullies, it's just more people were more open to other things…that would change how people might have looked at you" (Ricky)

This further emphasises how adolescent culture, more mature perspectives and social hierarchical structures were a more powerful force in creating change than the school, family or individual.

3.4 *I felt like I needed to fit in*: Exhausting efforts to belong in the hierarchy

After feeling rejected by a more powerful other, participants described ways they tried to re-connect and find a place in one of the groups in school. For example, Theo described becoming the "class clown so then everyone liked me". Hira's narrative suggested she adapted her behaviour to be accepted by the popular girls (e.g. becoming rebellious). Ricky described 'personality changes' to be able to connect and bond with others, even if these did not fit with his true self. For most, this sounded like an exhausting process, as Maria describes:

> I really tried to [sigh], I tried to get on with people in a way I could, but I was just, incredibly quiet [sigh]. I just didn't gel with anybody [sigh] and I don't know, it was difficult (Maria)

Her frequent sighs may demonstrate feeling 'fed-up' with her various efforts continually failing and thus reinforcing her view of being 'different' from and pushed away by others who she regarded as superior. They may also represent resentment for needing to try to act like a different person in the first place.

Ricky, Theo and Samuel described music as a way they tried to connect with others, forming groups with those who shared their music interests both in school and now. Samuel described his preferred music was pop music, but he listened to rap music instead, he stated that "the rap was hard and masculine" reflecting his fear of feeling emasculated. He also found a way to connect with others by learning magic, he said "It's really helpful socially. It's a good icebreaker*"*. Theo stated, "It's not really for me here, people in [location] aren't the Kanye's, Kid Creoles, the T-Rex of the world, you need to hang around with people more like you". This demonstrates the importance placed on finding connections with others 'like you' and expresses his ongoing wish to find true sense of belonging.

Ricky and Theo described drug use as a way of finding a place in the social hierarchy. For Ricky this was in school, he said "it sort of revolutionised the socialness of everyone which actually began to help things". His use of the term 'revolutionised' reflects a radical and fundamental impact of finding a place where he could be accepted. Theo's drug use occurred later, when he was 18 years old and after his psychosis experiences. He explained how this had a dual purpose:

> Because of the psychosis, I felt like I needed to fit in, I felt alone so I was fucked up anyways, so I just thought I might as well fuck myself

> up more, fucking myself up more was ok. It was two way, to fit in and to get off my head. Either one way worked (Theo)

He directly attributes feelings of not belonging to his psychosis experiences; this stigma seeming an inevitable rejection from the more powerful social norms. Loneliness leads him to conclude he was ‘fucked up’. He expresses a form of self-attack, wanting to escape from feelings of rejection and perhaps harm himself as others had harmed him. Farrah further explains the experience of stigma around psychosis:

> We talk about mental health, but when we talk about hearing voices and stuff…I think there are some parts of mental health that are acceptable to talk about, and some things that we brush under the carpet…How do I approach my friends and say ‘guys, I'm hearing voices’. (Farrah)

It seemed that whilst already feeling isolated and alienated by their bullying history, psychosis experiences exacerbated these issues and acted to further reinforce feelings of difference and social judgement. This view was expressed by most participants.

4. A process of evolving identity

This super-ordinate theme relates to a journey that participants described through various changes in identity, usually in response to verbal bullying. There was a narrative amongst participants that verbal bullying is less acknowledged than physical attacks yet has significant impact. For example, Farrah said, “that verbal stuff, for me, I feel like it sticks around a lot longer because you're not talking about it and it's just very deep within you and it just manifests”. Her reflection ‘it manifests’ suggests that she had noticed a difficult internal process occurring.

Being rejected by a stronger group and having identity attacked by bullies first led participants to question themselves, e.g. ‘Why me?’(Gemma), ‘What is so wrong with me?’,

concluding the bullies opinions must be true, “I just thought all the problem was within me” (Farrah). They then continued to bully themselves through self-critical attack, experiences which left them feeling they were losing parts of their true self. For six participants, this process later led to an experience of hearing critical voices, experiences that reinforced these negative views and pushed them even further away from social networks.

4.1 *What is so bad about me?* Questioning own worth

Most participants described a process of excessive thinking; beginning to question themselves for the names they were being called. Samuel described this like a “tonne of thought”, indicating the heavy weight it had for him:

> I thought things like of all things, kind of bashing myself in my head. I'd be like, "Why you like this? Why you so different?" Not different but, "Why you act like that? Why you not as good as them?" Or, "Why aren't you able to do stuff the same as other people?" and stuff like that. (Samuel)

Samuel’s use of the phrase “bashing myself in the head” suggests how self-attacking this process was. His questioning process involved social comparison with those who he viewed as better or more capable; suggesting he had adopted feelings of inadequacy.

Farrah recalled holding on to an abusive note given to her by bullies and stated, “That piece of paper, it felt like it solidified all the beliefs that I had. It was me reading it over, just me absorbing it and me thinking, ‘Okay, that's me on a piece of paper now’ and that was it”. This ‘absorbing’ and ‘solidifying’ of negative beliefs seemed to lead to a long-lasting negative self-view. Many participants also questioned their self-worth in relation to their desirability to others. This is shown when Farrah later moved to sixth-form college:

> I just thought there was something wrong with me because I couldn't make friends and I couldn't settle in. I just thought all the problem was within me. I just didn't enjoy anything about myself in that time. I just remember, again, being even more closed off (Farrah)

She reflects on how her struggle forming friendships was directed inwards, to concluding that something must be inherently wrong with her. Farrah's use of the word 'again' highlights how her feelings of isolation from school appeared to be repeating, perhaps escalating, as she became 'even more closed off' from others. Participants also wanted to offer advice to others who experience bullying, specifically referring to the impact on identity and self-worth:

> I want to preach to kids to tell them to have integrity in themselves. Know that they are not bad, wrong, not anything that any other people tell them. The soul only comes from what you say you are and what you want to do with your life (Samuel)

> I suppose the most important thing for people to remember is that the self is not determined by what others say to you (Maria)

These examples demonstrate how, on reflection, participants realised the grave detrimental impact of allowing others to define and determine their true self.

4.2 *I was looking in the mirror hating myself:* Developing an inner bully

After questioning their worth, participants recalled a process of denigrating themselves, expelling their true self in favour of a false portrayal from others. Theo used the term "depersonalisation" to describe this experience. Many participants described feelings of self-hate and had developed an inner bully that eventually became debilitating for them. Participants described believing that they were "never going to being liked by others" (Samuel). This occurred whilst still in school.

Alec recalled, "I hated myself so much; I was looking in the mirror hating myself because of the things people called me". Theo had drawn links between how this shaped his beliefs and later his actions by stating "people said I was weird and because I believed

I was weird, so I would then behave weirdly.” This gives an example of how a cycle of self-attack occurred, the participants inner bully maintaining low self-worth.

Farrah and Samuel both used the phrase “I just didn’t feel comfortable in my own skin” suggesting a sense of separation from their true self. Farah described this as resulting from a cycle of self-awareness and denigration:

> I even can't explain this feeling. It's like being in a situation and you're just so aware of how you are. I can't explain it. You're just so aware of you and you feel so awkward. You get a horrible feeling in that situation. Sometimes I almost want to step out of my own body but then I just think I can't stand being around myself...It's just a horrible cycle of being self-aware then putting yourself down and then feeling down… Those girls said things about how I look and from then on I always feel like I'm really fat and really ugly. Things like that. Sometimes, I say that I can *feel* the fat. I can *feel* my stomach. I can *feel* my chin hanging. I can *feel* my arms being really flabby and things like that” (Farrah)

Her initial struggle to put words to her feelings may reflect the challenge in being fully understood by others, or perhaps a belief that no one else feels this way. It evokes feeling of sadness when thinking of her wanting to step away from herself yet also having such low self-worth that she couldn’t bear to be around herself. Her emotive emphasis on the word “feel” suggests an embodied perception, locating her body as the source of her interpretation.

Through reaching the conclusion that they would not be desired or accepted by others, and being continuously reminded of this by both external and internal bullies, participants described feeling unable to relate to others:

> I literally changed as a person. I went quiet. Dead and quiet. So I wouldn’t say anything, I’d sit in the room with a bunch of people, quiet where I used to be chatty. Suddenly it was like I didn’t know these people any more, I couldn’t talk to these people anymore and I used to sit there in silence and not say a lot. (Ricky)

Ricky's description of interpersonal changes from "chatty" to "dead and quiet" occurred whilst still in school. It reflects the extent of the loss of his social self, to something that could never be recovered, buried in the past. He went on to explain how this leads you to seclude yourself because you can't be "engaging" enough for others to want to be around you. He recalled "this then brings you down like a snowball, one thing affects the other, that thing affects that and rebounds off this and you end up just in that big mess". This reflects a cycle of isolation that many other participants also described after developing harsh negative self-beliefs.

Some participants also expressed how receiving a diagnosis of psychosis only served to add to their already depleted negative self-view. This was either through hopeless beliefs about the future, such as "I just felt like my life was over" (Theo) or an increasing sense of inadequacy. For example, Theo describes "I felt like I was inadequate. Like a defaulted, like I was like a default mode. I felt like everything was defaulted in my life. I was like just a waste".

4.3 *They are telling me to be quiet, that I'm worthless, to stop talking to you, to kill myself:* Hearing Critical Voices

Six participants described hearing voices. Whilst two participant heard voices in the final years of school, for most participants, the experience occurred soon after leaving school (between 16 and 18 years old). For all these participants, the content of the voices phenomenologically linked directly to themes in their bullying history. Only half of these participants had connected their voices with bullying experiences in some way. Maria was quite hesitant in making such links. When asked if she had any understanding of her voices, she stated, "Not really, no. I just know I struggle with my mental health but I just, I don't know. I think bullying might have something to do with it, but I am not sure".

Gemma's first understanding of voices was a head trauma:

> "I had thought it was trauma because I had a dizzy spell ages ago and I hit my head on this marble and that's when the voices started so I thought it was trauma related but they couldn't find anything, so we think it's to do with all the build-up of everything going on (Gemma)

It was only after medical explanations were ruled out that she considered the accumulation of experiences (bullying, loss, parent's divorce). She refers to 'we' rather than 'I' suggesting others tried to help make sense of her voices.

Some participants stated they did not understand voices at all and tended to frame them as a medical symptom of psychosis. Theo gave neurochemical explanations, "I knew it was just brain chemistry, imbalance" explaining he had 'Googled' it. This highlights the dominance of medical perspectives online.

The voices heard by participants continued to attack their identity and thus reinforced negative beliefs about themselves. Ricky described "it would sound to me like they were going 'oh no you're a wanker'...it literally felt like people were calling me names quite a lot". Similarly, Farrah recalled "It sounds like they are real people telling you things and they sound so convincing". She also referred to the 'menacing' tone as more important than the content, a view shared by Hira. All participants described voices as commanding, critical and attacking. For example, Gemma stated, "They used to kind of tell me what to say what to do and like it put me down a lot", Hira stated:

> They said nobody liked me, it used to make my anxiety really bad, it used to make me paranoid any overthink everything, like 'no-one wants to talk to you' 'they don't want to be friends with you', your parents don't care about you, 'you're not going to do well at school', 'you're not going to finish your A Levels' (Hira)

The themes of this criticism in Hira's voices were the same as the themes described by Hira in her experiences of bullying (being alienated, feeling undesirable to others, unworthy and likely to fail in life) and in a difficult relationship with a critical father. This pattern of corresponding themes was true of all participants who expressed hearing voices. Maria recalled:

> They are telling me to be quiet, that I'm worthless, to stop talking to you, to kill myself. That they know my secrets. They have been telling me that I'm exaggerating and to stop exaggerating. That I'm being stupid for telling you things. That I'll never make anything of myself. That sort of thing. They don't really stop at all, reminding me of things I've done. (Maria)

Maria's past experiences of humiliation and shame were minimised by others, this is expressed in her voices. Expressions of 'exaggerating' and 'being stupid for telling' reflect earlier experiences of feeling unheard. This also expresses the relentlessness of the experience; participants continued to accept these attacking messages about themselves as truth. The worthlessness and hopelessness she expressed was common in participant accounts, leaving them frequently considering suicide. For example, Farrah described "They're telling you to kill yourself and to hurt yourself, and you don't deserve to live". Several participants described the impact of hearing voices on their education or work. For example, Gemma stated:

> I still get them [voices] now, putting me down a lot, if I try and do something good they say 'no don't do that it's not going to help you'. Which makes me, because of the mental health it's made me miss a lot, I've had to leave college, I've had to leave work, education because I can't be in an education environment (Gemma)

This emphasises how a cycle of being verbally attacked and developing a critical self can continue to be re-enforced through failing to achieve life-goals, further impacting self-worth.

4.4 *When I took away the label of a mental health issue then I felt I could progress in my life*: Understanding and moving forward

Although many described early challenges with services and expressed psychosis diagnosis as a further 'inadequacy', for most this improved over time. Participants appreciated opportunities they currently had with clinicians for general support and to learn more about ways to manage psychosis experiences. It seemed that receiving such forms of understanding helped them to move forward, as Samuel described, "When I took away the label of a mental health issue then I felt I could progress in my life". In this, he refers to finally having the opportunity to talk through his difficulties and feel understood and heard. At the time of the research interview, he had received a year of talking therapy:

> I think talking to [nurse] has helped. Also talking to [psychologist] also gave us hope…talking about stuff that helps you understand what you're going through and how to manage your life and how to manage your thoughts or something like that (Samuel)

Samuel had previously held a negative view of hope and feelings of professional mistrust. This extract demonstrates the value he now placed on his therapeutic relationships in creating renewed hope and learning practical ways to manage.

Only three participants had specifically explored their bullying experiences with clinicians. Hira explained "I mean I never understood it, when I see [name] he helped me try and understand it" … "he told me that maybe the voices kind of like saying what they [bullies] used to say to me when I was younger, like call me stupid and things like that".

Alec had 6 sessions of CBT-P approximately a year before the interview. He stated, "it helped to see…I'm not crazy and so forth, it's the way I am thinking from my experiences and stuff like this". Previous views of being 'crazy', perhaps reflect internalised negative stereotypes of psychosis. He expressed how a combination of therapy

and medication have continued to work together to support him over time, suggesting a sustained benefit:

> …the cognitive therapy…so I think about how I feel and I'm always catching myself. My medicine might not be working as well as they are, without thinking how I am supposed to be thinking" (Alec)

Farrah described how her relationship with clinicians has changed over time and reflects on her own responsibility for change, "When I first came I was really scared to talk to people. I didn't really want to deal with anyone I spoke to…I wasn't in the mindset to help myself". Perhaps it was 'scary' to accept help from professionals for fear of the same pattern of judgement, rejection and blame occurring. She had not yet spoken to her clinician about her bullying although believed it would be helpful to do so. She reflected on her experience of the research interview to explain the potential benefits of talking processes:

> It's been nice, because it feels like I've got a lot of things off my chest…I can correlate a lot of my behaviour and stuff happening today from my bullying. Just in general about being open and talking about problems to other people helps to do this better. When I talk about it, I can *so* go back to how I felt in primary school and I can still feel that sick feeling. I know I've kind of made sense of it by myself for a long time, talking about it does help.

This extract also expresses a vivid bodily to the sensations experienced in primary school when recalling the difficult experiences. She also notes that she has made sense of it by herself, perhaps due to her early expressions of learning she needed to cope alone.

Finally, several participants found it helpful to focus on future education or employment goals. For example, Gemma stated "my mental health is not going to knock me down now. I'm gonna do it, I'm going to become the paramedic that I wanted to become". This reflects a reengagement with society and a resilience that was apparent throughout her, and other participant accounts.

CHAPTER FOUR: DISCUSSION

Chapter overview

This chapter presents a discussion of the study findings. Firstly, an overview of the study aims will be presented and findings will be discussed in relation to previous theoretical and empirical research. The strengths and limitations will then be outlined, followed by pertinent clinical implications, service development issues and recommendations for future research. The chapter will conclude with a reflective account and concluding remarks.

Study aims

The aim of this research was to explore the subjective experiences of childhood bullying for individuals accessing services for FEP. A secondary aim was to explore whether individuals perceived their bullying experiences, or responses from others were relevant to their experience of psychosis.

Summary of findings

Four superordinate themes and fifteen subordinate themes emerged from participants' accounts. The findings from each superordinate theme are presented considering the extant literature. The discussion will be broadly structured by the corresponding subordinate theme, some themes will be grouped to allow for concepts to be discussed together.

Superordinate Theme 1: Facing daily threat

This superordinate theme reflected the vast distance between threatening experiences of bullying and the way participants thought it was viewed in society. It highlighted the threats of telling someone about their bullying and the various ways that

participants kept themselves safe. This included exploring how paranoia was made sense of. Finally, it reflected the accumulation of threat that participants described following, and in addition to bullying.

Is it trauma or just school?

Participants offered traditional ‘definitions’ of bullying, but when describing their own experiences, a much deeper layer of the bullying construct emerged. In addition to traditional forms (e.g. being hit or kicked, social exclusion, verbal name-calling), participants experienced distressing sexual and physical violence, or threats to kill as forms of bullying. This finding was supported by wider literature suggesting that youth may experience bullying as a traumatic exposure (Espelage, Hong, & Mebane, 2016; Newman, Holden, Delville, 2005; Van der Kolk, McFarlane & Weisaeth, 2007). Aluedse (2006) stated ‘Bullying is not just a child’s play, but a terrifying experience many school children face every day’. Current findings strongly support this view.

The more severe events were not mentioned by participants when orientating the interview with the initial bullying questionnaire tool. This leads to question both the construct of bullying and what may have been missed by measures widely used in the literature (e.g. Olweus, 1997; Schäfer et al., 2004). On the other hand, some might consider these abuse narratives, rather than bullying. Volk (2014) offers a critical examination of the construct of bullying and argues that such higher-intensity behaviour (e.g., rape, aggravated assault) need to be better reflected and distinguished between in definitions and measurement tools.

Three out of the four female participants reported abuse of a sexual nature. Sexual abuse is widely associated with psychosis (e.g. Varese et al., 2012), although research usually focusses on childhood sexual abuse (CSA) rather than peer sexual abuse (PSA).

PSA has been defined as 'any unwanted and non-consensual sexual behaviours occurring before the age of 16 years with a perpetrator who is less than 5 years older than the victim at the time of the abuse' (Maker, KemmelMeier & Peterson, 2001). It is thought that it is the contextual factors, like power and relationship differentials, that can lead to unique debilitating effects in PSA (Koverola, Proulx, Battle, and Hanna, 1996). This was demonstrated by study findings as the school context forced participants to face perpetrators daily, leading to feelings of anger, injustice, humiliation, fear of further assault and slut-shaming. Slut shaming is a term that describes a way of maligning girls for presumed sexual activity (Armstrong et al. 2014). It is argued that school culture, dress code and sex-education systems encourage a sexist and slut-shaming culture (Dockterman, 2014; Weiss, 2016).

Fearful consequences of telling

Fear and shame expressed by participants was exacerbated by the threats from perpetrators to stay silent. Participants reported this as the main reason that they did not seek help. The phrase 'snitches get stitches' epitomises the strong social norms against reporting others (Brown, 2007). This highlights an important issue because the core of many anti-bullying programmes is to encourage victims to tell someone (Glover, Gough, Johnson and Cartwright, 2000). Telling was reported by teachers as the 'number one' coping strategy they promote (Nicolaides, Toda and Smith, 2002). However, as the findings of this study demonstrate, the fear induced by the bully about telling, was far too high to even consider it as an option. This fear seemed driven by a belief that they would experience further abuse or become even more isolated. In a mixed-methods research project, funded to inform UK education policy, school pupils also stated that risks were too high to 'snitch' on bullies and schools offered inadequate protection from retaliation (Oliver & Candappa, 2003).

Participants' fear led them to remain silent for a long time, even if they had supportive family or friends. The risks were too high to seek help. It may be that bully threats left participants feeling trapped, as Alec expressed with his reference to 'prison rules'. Strong associations have been found between being stuck in aversive situations without ability to escape, and emotional distress (Brown & Harris, 1995; Kendler et al., 2003).

Finding ways to keep safe

Feeling too afraid to report bullying, participants physically avoided perpetrators to minimise opportunity for further hurt, or emotionally avoided e.g. 'I would just go and hide and take tablets' (Maria). Using physical or emotional avoidance as immediate survival strategies supports previous bullying research (Adams & Lawrence, 2011; Carney, 2008; Davidson, Inslicht & Baum, 2000; Mynard et al, 2000; Weaver 2000). Whilst developed in school as survival strategies, some participants expressed still using these strategies as an adult, adding to argument for early bullying interventions. For Ricky, this resulted in a formal diagnosis of agoraphobia which has been thought to be important in phenomenology, course of illness, and treatment response in psychosis (Pini et al., 2014). Within CBT-P models, Garety et al., (2001) and Morrison (2001) both proposed that behavioural coping responses such as avoidance, act to maintain psychosis symptoms.

Other coping strategies were described by participants to regulate their overwhelming emotions, such as self-harm, suicidality, substance use, or emotionally cutting off. These findings may support prior research where higher rates of self-harm have been found in bullied individuals (Fisher et al, 2012; Lereya et al, 2013). Within the frameworks of Morrison (2001) and Garety et al (2001), self-harm might be understood as a 'maladaptive coping response' thought to maintain low self-esteem and psychosis.

Increased suicidality is also found in bullied individuals (Herba et al., 2008). In addition to wanting an escape from bullying experiences, suicidal thoughts were expressed as a way of escaping overwhelming psychosis experiences. This may support previous associations in the literature between self-harm and suicidality and psychosis (Nordentoft, Madsen, & Fedszyn, 2015; Mork et al., 2012).

From vigilance to paranoia

Most participants made sense of current experiences paranoia in the context of bullying; they noted that their first paranoid feelings started whilst being bullied. Normal worries and attempts to safety-seek seemed to become paranoid experiences and were later framed as a psychosis symptom. Maria had not used the words paranoia or psychosis and held full conviction in her beliefs leaving her frustrated with not feeling believed by clinicians. These findings may support a continuum view between good and poor mental health (Verdoux & Van Os, 2002).

Participants described how day-to-day occurrences led them to believing they were targeted, followed, watched, listened to, or humiliated. For example, Alec described seeing a bus and quickly concluding it was waiting for him, Farrah saw people talking and quickly concluded they were laughing at her. This supports the ideas of Freeman et al (2002) where paranoia is conceptualised within a model of anticipation of threat and danger. Similarly, the content of persecutory delusions or paranoid thoughts have been found to have common themes of physical, social, or psychological threat and defeat (Freeman & Garety, 2000).

Various cognitive processes might be relevant here. Prior research has found that patients with paranoid delusions tend to ‘jump to conclusions (JTC)’ and have poor theory of mind (e.g. Frith & Corcoran, 1996; Garety et al. 2001). Ward and Garety (2017) considered a dual-process in which distressing delusions might involve an over-reliance on

fast thinking (e.g. JTC) with reduced or ineffective slow thinking (e.g. less reflective hypothetical mind). They suggested that belief inflexibility may manifest in this process.

The findings may tentatively support previous research which has suggested that there is an association between bullying and paranoid ideation (Bird et al. 2017; Catone et al. 2017; Jack & Egan, 2017; Masillo et al., 2017; McDonnell et al., 2017; Valmaggia et al., 2015). However, claims in these studies were based on paranoia measures and as current findings further highlight, may have been capturing responses to real threat. This might indicate a need for better developed measures to distinguish between the concepts of paranoia and actual current threat in bullying.

An escalation of external threat

Some participants described a period prior to the onset of psychosis, whereby various life events occurred. For some this was after bullying had ended, for others, bullying was still ongoing. These acted as additional environmental threats. They were based around themes of loss, family dispute, educational concerns, or financial insecurity. This may offer support for arguments of a dose-response effect in psychosis (Catone, 2016; De Loore et al., 2007; Lindgren et al., 2017; Van Dam et al., 2012).

Participants expressed confusion and fear when discussing how frightening and shocking it was to experience psychosis. It is common for individuals with paranoid feelings or who hear persecutory voices to believe that they have to remain highly vigilant as a way of staying safe (Birchwood & Chadwick, 1997). Therefore, both the external world and the internal world become sources of threat. Previous research has also highlighted the threatening nature of psychosis experiences (Catone et al., 2016; Goff et al. 1991; Hardy et al., 2005; Read and Argyle, 1999). Whilst noting this ongoing threat is an

issue for many individuals who experience psychosis, it seemed to add an additional layer to those who also experienced daily threats from bullies.

Superordinate Theme 2: Overcoming systemic mistrust

This superordinate theme reflected the unhelpful responses from the systems around participants, firstly in school and later from mental-health services. The general feeling of mistrust expressed in this theme included expectations of dishonesty, unreliability and even additional threat from professionals.

The struggle for help

Whilst it was expected that some teachers may not have taken enough action or been entirely supportive, it was surprising to hear so many stories of total neglect, blame being placed on the victim, or situations where teachers were complicit in bullying abuse. James et al. (2008) highlighted the neglect of teacher-pupil relationships in bullying research. Aluedse (2006) found that teacher's personal views of seriousness, assumptions about the victim's responsibility, school culture and whether they felt empathy for the victim all influenced their responses.

It was particularly surprising that a teacher told Maria that sexual harassment is 'just what boys do' and to ignore it. This is both re-enforcing sexist culture and a form of systemic neglect. School-girls being subject to sexist social values was also found in UK school research (Oliver & Candappa, 2003; Ringrose & Renold, 2012) and wider educational literature (Kehily 2002; Dobson & Ringrose, 2016). Systemic neglect remained present even when schools had clear anti-bullying policies, supporting argument that such policies are inadequate in offering protection (Oliver & Candappa, 2003; James et al., 2008).

Participants hoped for validation, support, and action to be taken against the bully, but there were no examples where this was achieved. Furthermore, it only took one failed response from a teacher to prevent any further attempts to tell others. This supports research that suggests adult-child relationships are especially important in bullying situations and can affect the child's ability to cope (Aluedse, 2006). Relying on adults to intervene is considered paramount (Craig, Pepler & Atlas, 2000). As younger children particularly look to adults to help, the poor primary-school teacher responses (described by Farrah, Gemma and Hira) may have been even more difficult to tolerate.

Participants stated that feeling blamed and unheard influenced not only the emotional distress at the time and feelings of loneliness, but their beliefs about help-seeking in future. This is key when considering most participants entered services after a suicide attempt, when self-harm was discovered by family, or police involvement. This relates to previous findings which suggest individuals experiencing FEP rarely initiate help-seeking for themselves (Addington, Van Mastrigt, Hutchinson & Addington, 2002). Therefore, crisis or socially unacceptable behaviour inevitably acts as a catalyst (Bergner et al., 2009; Morgan et al., 2006). Perhaps seeking help is already a challenge for young people, so adding a previous negative professional response to this, may make help-seeking an even bigger step.

There was a help-seeking gender difference in the findings, female participants tried to ask for help from a teacher at least once in their account whereas most male participants did not. Similarly, male participants engaged with psychosis services later in their journey than female participants. Whilst noting that generalisations cannot be made from the study sample, previous research has consistently found that girls are more likely than boys to seek help for bullying (Hunter, Boyle & Warden, 2010) and men seek professional help less frequently than women (e.g. Addis & Mahalik, 2003). Samuel's

resistance to being seen as a 'weak' man suggests that gender role-socialisation paradigms may have played a role; vulnerability conflicts with social messages men receive about self-reliance, resilience, and emotional control (Addis & Mahalik, 2003; Pleck, Levant & Pollack, 1995).

In addition to expressions of dissatisfaction and feelings of apathy arising from their failed help from teachers, participants expressed a concern of disclosing psychosis experiences for fear of judgement. Stigma is highly prevalent in psychosis populations; it may lead to issues such as social exclusion, lack of power, shame and discrimination (Crisp, Gelder, Goddard, & Meltzer, 2005; Crisp et al., 2000; Wood et al., 2015). Considering that participants had already faced such issues in their history, disclosing psychosis experiences to others only risked further criticism and isolation.

Feeling unheard by services

Most participants had relatively positive relationships with their key professionals in psychosis services but stated that this took time to achieve. Anti-psychotic medication was the initial form of treatment offered and participants expressed dissatisfaction with this. This supports previous findings in adolescent research where medication as a treatment option was not favoured (Jorm & Wright, 2007). It also highlights the dominance of the medical model in mental health care (Read et al., 2013; Mosher Gosden & Beder, 2013).

Many participants expressed that they still felt unheard or that their experiences were not validated as bullying was rarely, if ever, discussed with clinicians. For some, it was ticked on a form but never followed up which seemed even more invalidating. This supports the argument that it is ineffective to include abuse questions in admission forms or instruct staff to ask about abuse without adequate training to respond to disclosures (Dill, Chu, Grob, & Eisen 1991; Read and Fraser, 1998; Sampson & Read, 2017). Furthermore,

it was surprising to find that some of those who had CBT-P therapy had not been asked further detail about their histories of bullying. This suggests that even within evidence-based treatments, important elements of experience can be missed.

Participants believed that clinicians were not interested, too focussed on medication and current concerns, or they were scared to discuss it. Disclosure of personal traumas can feel distressing for those who experience it, and for those who are listening. Without adequate support for hearing distress, workers may employ the 'silencing response' as a self-protective strategy (Read & Dillon, 2013). Therefore, there is potential for avoidance from both parts of patient-clinician relationships. Previous research has also identified that the proportion of abuse identified by staff in services in low (Sampson & Read, 2017), although literature in this area is limited in quantity and quality (Hepworth & McGowan, 2013). Considering that bullying is not usually considered as a form of abuse, it is arguably even less likely that patients will be asked if they have experienced it. Middleton, Stavrapoulos and Dorahy (2014) argue "We have to avoid passively opting for silence if we are to be part of the solution rather than an extension of the problem" (p.581).

In 2008, the National Health Service (NHS) published guidelines outlining expectations that all service users are asked "Have you experienced physical, sexual or emotional abuse at any time in your life?" (National Health Service, 2008). There is little follow-up research in the UK to explore how these guidelines have been implemented. Furthermore, these categories are ambiguous and were not intended to include bullying. Therefore, although bullying was a relevant form of abuse for participants, it is likely it will continue to be missed by clinicians. Boyle (2013) argues that mental health services deny the importance of life experiences and social context in favour of social control and power (e.g. managing risk). The cultures in which psychosis services operate may be deeply rooted within these wider social and political contexts.

Superordinate Theme 3: Negotiating power imbalance

This superordinate theme related to the power differentials that operated throughout both bullying and psychosis experiences. Participants also highlighted the importance of social hierarchies in their worlds, with a change in the organisation of social power being the only thing that ultimately brought an end to their bullying. This finding stresses the importance of social context, which was found to be missing from the most prominent previous literature around bullying and psychosis (Hamburger, Basile, & Vivolo, 2011)

'Positioning of bully as powerful, self as weak' and 'Power of the group'

Participants positioned themselves as weak in comparison to their bully, or a group of bullies and/or bystanders. This supports the importance of power in the core concept of bullying (Olweus, 1993; Volk, 2014). The concept of power differential explained by participants in a way that positions them as weak, powerless victims may offer further support for the cognitive paradigm of understanding psychosis. The victim schema model (Rosen et al., 2007) specifically proposes that these schemas can occur from bullying and can continue to make individuals vulnerable to further bullying experiences. It also proposes that a victim schema may contribute to psychotic appraisals of normal intrusions. For example, because of her bullying experience, Farrah explained holding a very low opinion of herself and a belief that others are all against her and will not like her. So ever since the bullying, if she sees other people talking, she interprets this to believe they are saying negative things about her or are persecuting her.

The power imbalance also highlights the issue of control. Because participants viewed themselves as the weak and were trapped within a wider school system of power, most held little belief over their own ability to change their situation. This left them with a hopeless view of the future. Believing that others are in control of being able to change

the situation is known as having an 'external locus of control' (Rotter, 1966). This finding may support prior research that suggests having an external locus of control may act as a pathway in the association between bullying and psychosis (Fisher et al., 2013). In contrast, Theo recognised his ability to take control of the situation himself, suggesting an 'internal locus of control'. He explained how he actively shifted his power position to move from victim to bully. Theo's account highlights that there are not always clear divisions between the different bullying positions and admitting bullying others was difficult when he had also been in a victim role. There are therefore challenges in distinguishing between such roles, as previous bullying research has attempted (e.g. Sourander et al. 2007, 2009)

The only time participants did not consider themselves to be the weaker side of the bully-victim power dynamic was in cyber-bullying. Participants explained they were able to 'just block' the person, thus giving them more control in regaining power. Their accounts reflected a contrast to research that suggested cyberbullying is just as distressing (Kowalski, Limber & Agatston, 2008), or could lead to worse consequences (Bauman & Yoon, 2014) than traditional forms.

Participants often referred to a neglectful bystander. This supports previous research where bystanders are found to rarely intervene (Craig & Pepler, 1997; Oliver & Candappa, 2003; Salmivalli et al., 1996). There were very few examples where bystanders supported the participants; it was more likely that others would join in by laughing, leading to further humiliation. Some participants made sense of this by explaining that the bystanders would also have feared reprisal from the bully. This supports Ortega's (2010) 'law of silence', where bystanders stay silent through fear of becoming victims themselves.

‘ Social power – being positioned as different’ and ‘Exhausting efforts to belong to the hierarchy’

Common participant narratives around social hierarchies and their power, convey the importance of these issues to participants. There is however comparatively little research on bullying where it is conceptualised as being phenomenologically group based and positioned within a network of social systems. Participants conveyed the influence social hierarchies held on their feelings of self-worth, connectedness, sense of belonging and security. This supports research around self-worth being derived from group membership in pre-adolescence (Verkuyten, 2007).

All participants placed high importance on social context and belonging to social groups, whereas parent-child relationships formed a minimal part of participant accounts. This might be explained by the possible shift in influence from vertical caregiver relationships to horizontal peer relationships during adolescence (Carlisle & Rofes, 2007). This may also reflect a fundamental need to be accepted and to belong (Baumeister & Leary, 1995). Most participants described a desire to be accepted by groups from which they were ostracised; perceiving them to be superior in the hierarchy. Superiority seemed to be defined by material belongings, social media ‘likes’, physical attractiveness and multiple friendships. These findings support Social Rank Theory (Gilbert et al., 2003) which highlights that an involuntary, unwanted social position is associated with shame, social anxiety or depression, rather than the position itself.

The social comparisons in the findings may suggest issues of inequality are played out within school systems from an early age. Furthermore, belonging to a more superior group required access to equal social resources. Wilkinson and Picket (2009) explored the powerful relationship between relative poverty in societies and social, health and mental health outcomes. They found that ‘rates of mental illness are five times higher in the most

unequal compared to the least unequal societies'(p.181); the UK was in the top 4 most unequal societies. Poverty and racism are also significant factors in psychosis; Read, Johnstone, Taitimu, (2013) argue that the impact of belonging to a disempowered group is minimised by the over-emphasised bio-genetic concern.

The importance of social power arising in participant narrative might suggest that these need further consideration in treatment. It might thus be argued that CBT-P may not adequately address such issues if focussing more on the role of individual cognition and behavioural responses. This potential limitation supports the arguments around the neglect of environmental factors in CBT-P (e.g. Harper, 2001).

The World Health Organisation (2009) notes the deficits in current health and legal systems where containing, assessing or treating people are prioritised over promoting or sustaining mental health. The views of participants were widely shaped within a context of sexism, racism, classism and mental health stigma. Therefore, it is argued that these wider discourses also need to change to create healthier societies for children in schools.

The Power Threat Meaning Framework (PTMF) (Johnstone & Boyle, 2018) is a framework which offers an alternative to diagnostic understanding. It aims to create life narratives that are hopeful, rather than individuals feeling devalued as 'mentally ill'. This framework is relevant to study findings as it highlights links between issues such as social power, trauma and threat. It also frames how the meaning of these factors and the ways that people survived are important. Current findings may therefore offer support for the value of the PTMF in understanding psychosis. The PTMF may therefore offer an empowering way of helping young people understand their difficulties. Although only in the early stages of application, it has received positive feedback in youth social contexts

(Aherne, Moloney O'Brien, 2019) and in educating teachers to being more attuned to students (O'Toole, 2019).

Superordinate Theme 4: A process of evolving identity

This theme reflected the process in which participants' identity seemed to shift and evolve over time. Identity is defined as 'an abiding sense of the self and of the relationship of the self to the world' (Northrup, 1989) and the adolescent period is considered pertinent in identity development (Schore, 1994). The theme reflects the low self-worth experienced after persistent verbal attack. Participants started to question their true identities, develop an inner bully and experienced hearing voices. For most, voices appeared after they had left school and bullying ended.

'Questioning own worth' and 'Developing an inner bully'

Most participants directly attributed a loss of self-confidence and self-esteem to experiences of bullying. Low self-esteem has been identified as both an antecedent and consequence of bullying (Egan & Perry, 1998; Hawker and Boulton 2000; Olweus, 1993; Wolke, Lee and Guy, 2017). Study findings may support prior research which has found low self-esteem and negative core beliefs as implicated in both the development of psychosis (e.g. Smith et al., 2006; Van Os, 2000) and the maintenance of symptoms (Garety et al., 2001; Morrison, 2001).

It is argued that adolescents, over time, acquire an increasingly internal sense of their personal attributes (Suls, 1989). In relation to bullying experiences, Olweus (1993) proposed the voice of the original source separates and then the inner bully continues to function autonomously. For participants, experiences of other's criticism seemed to become internalised as they recalled starting to both believe and tell themselves they were 'fat', 'ugly', 'useless' or 'stupid' and that no one liked them. Therefore, throughout

participants accounts, core beliefs were expressed about themselves as flawed, vulnerable or weak, and others being unsafe, untrustworthy and threatening. This might support arguments within cognitive models where early exposure to threat (through trauma or adverse experience) is thought to increase vulnerability to misinterpretation of normal intrusions. These beliefs are also thought to be reinforced through psychosis experiences (Morrison, 2001).

Hearing critical voices

Whilst in school, both throughout and after bullying ended, the internal bullies of participants persisted in self-attack. It seemed that later in their journeys (for most in the first two years after leaving school), these same messages sounded like they were coming from an external source, their ‘voices’. This was described by participants as sounding like they were ‘real people telling you things’, and ‘calling you names’. For all participants who heard voices, the content of the voice was phenomenologically the same as the ways in which they described both their original bully and their internalised bully.

The congruence between the themes in voice-hearing and bullying experiences adds to the findings observed in prior research where the content of psychosis experiences was significantly related to abuse history (Hardy et al., 2005; Read & Argyle, 1999; Read et al., 2002). All participants’ voices were of a persecutory nature, or commanding self-attack, based on ideas of worthlessness and being globally disliked. This may support the findings of the Catone et al. (2016) mixed-model study where a significant association was identified between themes of persecutory delusion and humiliating experiences.

Whilst noting bullying is a different concept, it might be helpful to think about the findings in the context of the research of where sexual and physical abuse history was particularly linked to commenting voices and command hallucinations (Read et al., 2002;

Romme & Escher, 2006). However, it may also be true that psychosis symptoms are always related to an individual's history so if trauma forms part of this history, it is not so unexpected for it to arise in anomalous experiences (Morrison, Frame & Larkin, 2003). Furthermore, it is necessary to note the complexity of co-occurring adversities whereby specific pathways are difficult to explore (Shevlin et al., 2015)

Previous research suggested if bullying reduced or stopped, then psychosis experiences also decreased (Kelleher et al., 2013). In this study however, most participants' voices continued, or only started after the bullying ended. In wider trauma literature, it has been proposed that continuation of voices after the end of traumatic experiences is more common if the child experienced frequent voices and high levels of anxiety and depression (Escher et al., 2004).

A number of cognitive models of psychosis explain the way that voices (auditory hallucinations) might develop (Garety et al., 2001; Larkin & Morrison, 2006; Morrison, 2001; Freeman et al., 2002). Birchwood et al. (2000) proposed voice-hearing can be fuelled by negative schemas of social humiliation and subordination, following social adversity in childhood. Garety et al (2001) went on to argue that hearing a voice may occur after a triggering event or if an accumulation of life stress leads to normal cognitive processes being disrupted. The individual may then believe this to be from an external source rather than internal. The voice may be maintained by ongoing cognitive biases, their appraisal of its meaning, ongoing anxiety, avoidance and low self-esteem (as found in the superordinate theme 'facing daily threat').

Morrison (2001) proposed that it is the 'misinterpretation' of intrusions (such as voices) that create distress, rather than the intrusions themselves. Most participants described their voices as 'scary' because they had no idea what they were or where they

were coming from, but they felt like real threats. An example is where Farrah stated, "It sounds like they are real people telling you things and they sound so convincing". Moreover, Morrison (2001) highlighted how these interpretations are understood as psychosis as they are not socially or culturally acceptable. Furthermore, some participants described a spiral of experience. For example, where bullying led to initial social withdrawal, then isolation worsened mood and psychosis experiences, leading to even further social avoidance and worsening mood.

Although the analysis identified a phenomenological link between participants' bullying experiences and their voices, several had not made such links. Instead, they expressed complete confusion about the voice, or framed it as a medical symptom of psychosis. One participant adopted a specific neurobiological view, based on the dopamine hypothesis (Howes & Kapur, 2009). He stated this was from self-research on the Internet, highlighting the societal dominance of the medical-model, a topic widely addressed by Read & Dillon (2013). Only three participants had made direct links between their voices and bullying experiences; they had all accessed CBT-P therapy and stated that prior to this they had no understanding. This highlights a role for clinicians to normalise and support patients with understanding their psychosis experiences.

Understanding and moving forward

All participants expressed confusion and fear around their experiences of psychosis and a desire to better understand them. They also expressed changing views on their psychosis experiences over time. This supports previous qualitative research where young people have been found to seek meaning for their experiences and the explanations they adopt can change over time (Boydell et al., 2010). Arguably the search for meaning helps young people to remain hopeful amid distressing psychosis experiences (Perry, Taylor &

Shaw, 2007). Prior research has suggested that people express a wish to reconcile problematic past experiences to progress in recovery (Pitt et al., 2007).

Participants who accessed psychological therapy expressed that they had some opportunity to make sense of their experiences through this. They noted benefit from cognitive behavioural therapy for psychosis (CBT-P), (Chadwick, Birchwood & Trower, 1996; Fowler, Garety, & Kuipers, 1995) expressing it was helpful in learning more about psychosis and learning ways to manage their thoughts. This supports findings of other qualitative research which highlighted the educational element as a benefit of the CBT-P approach (Messari & Hallam, 2003).

Participants did not consider themselves to have 'recovered' from bullying, or psychosis experiences. Instead they referred to their current situations as ongoing processes of learning with a focus on trying to pursue their own future goals. Examples included re-engaging with education or focussing on career paths. Existing literature explores the re-engagement with life goals as indicators of recovery (Ramsay et al., 2011; Yarborough et al., 2016). Most participants were in education or part-time employment which helped them to have a more hopeful view of their future.

Strengths and Limitations

Whilst research had previously established that childhood bullying was associated with psychosis, this was predominantly using quantitative approaches in non-clinical samples. A further quantitative study may have had the advantage of using statistical analysis to explore possible relationships between bullying and psychosis in clinical populations (EIP services). Through the use of larger sample sizes, it may have also been useful in generalising findings to a wider population, something which can be helpful for policy and service design as these often rely on statistically sound data to support funding

decisions. However, using an IPA approach has instead broadened this research base by offering a rich exploration of bullying for individuals experiencing early psychosis. Therefore, those working with psychosis are offered a far more in-depth understanding of the issues that people may have faced along their journey into the service, including the wider influences of social power and systemic mistrust.

The IPA approach also led to findings which offer further support to those working with CBT-P frameworks. For example, offering insight into the ways psychosis developed for participants over time, how they understood it, how they continue to respond to these experiences (e.g. avoidance, hyper-vigilance) and what they find helpful (e.g. understanding experiences in the context of their bullying history). This depth of understanding could not have been achieved through standardised measurement tools. The added depth of experience can help in many areas of clinical work, from considering barriers to engagement, to helping clients to formulate and understand their own individual psychosis experiences in the context of bullying history. IPA therefore offered a more person-centred approach.

Using an IPA approach has broadened this research base by offering a rich, in depth exploration of bullying for individuals experiencing early psychosis. Also, it has contributed to our understanding of participants' sense-making processes (Smith et al., 2009). This focus on individual lived experiences could not be offered by standardised measurement tools (Braun & Clarke, 2013; Sofaer, 1999).

When considering strengths and limitations of the research, it is important to consider its validity and quality in line with the Yardley (2000) principles; sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance.

Sensitivity to context refers to the position of the research, considering whether the analysis and interpretation is sensitive to the data, the social context and the relationships (between researcher and participants) from which it emerged. In early stages of planning the project, the context was well considered. The choice of IPA as a methodology reflects the wish to ensure that contextual areas previously neglected in research were captured. The researcher spent considerable time engaging with services, both staff and service-user, to ensure the research design was sensitive to the population. All materials were drafted and re-drafted with service-user input.

The researcher was able to draw from clinical skills in working with adolescents to establish rapport and engage the participant prior to interview. Furthermore, the use of the 'bullying questionnaire' orientated them to the topic and eased them into the interview, without feeling too overwhelmed by a more open questioning style. This was considered a helpful tool for this purpose, however the content of the questionnaire (and the PIS) may have pre-empted participants towards biased definitions of the construct.

The researcher was keen to include participant extracts to allow the voice of participants to be well represented. This proved a challenge as inevitably the focus on hermeneutics via researcher interpretation may have curtailed the participants' own voice. This was noticed in analysis where the stages of IPA move the researcher away from participants words (Smith et al., 2009). It was also noticed in write-up where only a selection of verbatim extracts could be used. However, the anxiety felt during this part of analysis reflects the desire to remain sensitive to the perspectives of participants.

The study met the principle of commitment and rigour through the degree of attentiveness to the participant during interviews. Transcription was carried out by the researcher as a way of committing to the accounts by engaging with the data as much as

possible. Also, the idiographic focus paid significant attention and commitment to drawing themes from each individual account before moving to the next. An IPA training event was attended where the quality of the interview schedule was reviewed by experienced IPA researchers. Furthermore, after transcribing the first interview, a telephone consultation was held with one of these experienced IPA researchers to reflect and ensure alignment with an IPA methodology.

The principle of rigour can also apply to the appropriateness of the sample. Due to researching within a specific clinical sample, a purposive sampling method and well-considered inclusion criteria was used to ensure that the participants aligned with the aims of the research. It is argued that IPA research should have a reasonably homogenous sample. The sample had the advantage of being homogenous in age group, bullying experience and presenting mental health experiences. This allowed focus on a specific population who had shared both experiences of psychosis and bullying. According to Smith and Osborne (2003), this sample would be considered homogenous as it is 'a closely defined group for whom the research question is significant'. Therefore, whilst heterogeneity in gender, ethnicity and time spent in psychological therapy is noted, the sample was still homogenous in relation to the aims of the study. The variability of ethnicity is considered here a strength considering the extent of previous research being heavily biased towards White British populations. Including both genders allowed patterns to emerge between male and female accounts which would otherwise have been missed. Furthermore, wider systemic issues became more apparent with a broader demographic, such as societal gender narratives and experiences of racism.

Two transcripts were checked by supervisors to see if similar themes and interpretations would be reached if others had analysed the data. However, through considering the inherently interpretative activity within IPA, it is naïve to assume that

researchers from different theoretical positions or personal backgrounds would have made sense of the participants' experiences in the same way. It was also not possible to triangulate the data within the scope of this study; accounts from teachers, clinicians or families might have offered alternative perspectives.

The principle of transparency and coherence refers to the clarity in which the research is presented. The researcher has attempted to enhance this principle by carefully describing the stages of the research from the epistemological positioning, to design of the research materials to analysis of results. It also includes an extract to offer transparency of the analysis process. The presentation of themes was drafted and re-drafted in discussion with supervisors, within IPA principles outlined by Smith et al. (2009). Furthermore, a reflective log was used and discussed in supervision to remain transparent about reflections throughout the process.

The principle of impact and importance is met through considering the relevance of findings. To the best of the researcher's knowledge, this is the first research project exploring childhood bullying in a clinical population of individuals who experience FEP. Bullying, often considered a normal part of childhood, led to significant distress for individuals who later went on to experience psychosis. This was exacerbated by the lack of response from those they reached out to for help. Also, bullying experiences were not well considered in services. This offers a novel insight into how psychosis services might frame the difficulties of young people. It also provides learning for the ways that both services and schools might better support those who experienced bullying.

Sampling Limitations

The researcher acknowledges a key limitation is that the design and small sample size means that it cannot be generalised or explain casual relationships (Smith & Osborne,

2003). It is possible that the difficulties described by participants were independent of their experiences of bullying; they may have had pre-existing vulnerabilities (Gladstone, Parker & Mahli, 2006). Furthermore, considering the complexity of childhood adversities, it remains difficult to isolate bullying as a factor in later symptomology (Carlisle & Rofes, 2007).

Most participants who took part had accessed talking therapy. All EIP patients are offered psychological therapy so this was, to some degree, expected. This may however bias the findings as those who have accessed talking therapy may make sense of their experience in different ways from those who have not. For example, the meaning they made of their experiences may have been influenced by clinician perspectives; they may have been more self-reflective or coherent in their narratives and more comfortable in the setting.

Asking about bullying and how they made sense of psychosis experiences in the same interview may have encouraged some interpretation to occur within the interviews or bullying being more implicated in psychosis experiences than would otherwise be the case. An improvement might have been to carry out interviews on different occasions, one around how they made sense of psychosis and the other to focus on bullying experiences.

Recruitment was challenging, a large obstacle was due to MDT staff not being fully aware of client histories. This supports the participants' explanations of some staff remaining more focussed on current symptoms than past experiences. As such, only those who had already disclosed bullying would have been approached by staff. This suggests potential bias as those who had not disclosed may have offered different accounts. Furthermore, those with less severe bullying might not have felt the need to disclose or motivation to take part. On the other hand, some clinicians expressed anxiety about asking those with severe bullying history, due to a worry about de-stabilising them. Whilst

protective, this raises an ethical issue around decision making for research and how clinician anxiety may act as an overly cautious gate-keeper to those who might want to share experience.

Several more participants were identified by staff members but after further consideration, decided they did not want to take part. The reasons given were the anxiety of meeting someone new, or that they believed talking about their bullying would be too distressing. Interviewing on Trust service premises had aimed to address some of these concerns, offering a familiar environment and a sense of safety as the staff they knew were in close proximity. However, it became apparent during recruitment that there were other potential participants who did not want to come into the service building. This was because they felt unable to leave the house and only wanted to take part if the interview took place in their home. Considering the findings of this study and the potential for interpersonal and systemic mistrust, such reasons for not wanting to participate make sense. It may be that only those who had managed to overcome some of these fears felt able to take part. An improvement may have been to include home visits in the study design. This may have impacted the findings as other participants might have provided different accounts, particularly in relation to anxiety, trust or social isolation.

The participants discussed trauma and abuse experiences within the framework of bullying. This may suggest an overlap between various constructs, indicating ambiguity in bullying definitions. Arguably, such findings may be conceptualised within abuse or trauma constructs rather than bullying.

Clinical Implications

The study has shown that participants found bullying highly distressing and relevant to their overall mental health difficulties. There are therefore implications for both clinical and educational settings.

In terms of clinical settings, participants reported bullying as a traumatic exposure, yet perceived others to view the experience as a harmless rite of passage in childhood. This minimisation of bullying, and vastly neglected research base on the topic, helps to explain why it may not be at the forefront of clinicians minds. This argues for better consideration of the concept of bullying within trauma discussions in clinical settings. This is particularly important in EIP services as the dominant age demographic is closest to the period in which bullying may have occurred.

Findings indicated EIP patients were keen to discuss bullying with clinicians and many believed that it was being missed in services, even if they had CBT-P therapy. There were also expressions of appreciating opportunities to discuss life histories and the impact on mental health. This supports the value of offering talking therapies within NICE guidelines (NICE, 2015). It is also suggested that clinicians who offer CBT-P ask directly about experiences of bullying and offer opportunities to explore any potential links between bullying and psychosis experiences.

It is recommended that clinician's follow NHS published guidelines (NHS, 2008) by asking EIP patients about abuse, with an additional more specific question "Have you experienced bullying?". Services offering questionnaires on assessment need to ensure that if they are asking patients to record bullying on forms, they are also following up these responses. To facilitate these processes, it is imperative that barriers to questioning about abuse histories are explored with clinicians in teams, supporting previous

recommendations around offering adequate training to respond to disclosures (Dill et al. 1991; Read and Fraser, 1998; Sampson & Read 2017).

Participants expressed histories of systemic mistrust, and a broader mistrust of other's intentions. Therefore, individuals new to EIP services may have taken time to accept help and struggle to engage or sustain relationships with staff. This may be even truer for male patients where concerns around being viewed as weak were present. Furthermore, their entry to services might be following crises and family seeking help for the patient. These complex interrelated issues can be challenging for clinicians. An awareness of bullying history may help empathise with initial systemic mistrust. It is also recommended that EIP services and schools consider adopting trauma-informed care models (e.g. Sweeney, Clement, Filson, & Kennedy, 2016). These aim to emphasise physical, psychological and emotional safety to enable patients to build a sense of control and empowerment.

The findings indicated that school systems can be neglectful in bullying situations. However, this also means they have some power to prevent more devastating impact. Firstly, staff could be offered training about this impact and how they may be the first (and last) person an individual who is being bullied might disclose to. Adopting a trauma-informed model in a school might involve noticing and exploring behaviour changes in pupils in the context of their experiences. Reviewing anti-bullying policy may help to facilitate change, such as including more confidential opportunities that could make disclosure easier, rather than promoting reliance on the victim to approach a teacher. Confidential sources of support are also recommended to acknowledge and validate children's feelings as a priority, before considering solutions. This would allow children to have some control and agency over disclosure and be supported in preparation for possible

consequences. Such an early-intervention may help to model and encourage more effective ways of coping from a young age.

It may be more beneficial for schools to prioritise tackling the social culture that facilitates bullying, rather than the individual incidents. This supports recent recommendations to tackle bullying which highlight the importance of reducing systemic inequalities and understanding teachers' complex roles in school (Naseem, 2017). This may be through teaching topics around valuing difference, promoting acceptance, racism, sexism, peer sexual abuse, or encouraging interaction between subcultures. Gender and culturally sensitive bullying models have also been recommended to address these socially constructed power relations (Oliver & Candappa (2003).

Recommendations for future research

Through systematic review and exploration of previous literature, a gap in the literature was found as the role of bullying in psychosis was not well understood. Research also neglected the wider complex system around the individual. No qualitative studies were identified that added depth to the findings of possible relationships between bullying and psychosis in quantitative studies. This study aimed to start to close this gap by exploring the subjective bullying experiences of individuals who accessed EIP services.

Participant narratives indicated a journey leading to paranoia (originating from threat and safety seeking responses) and a journey leading to critical voice-hearing (originating from name calling and attacks on identity). It may be useful to further explore whether these journeys represent different pathways and psychological processes in psychosis, building on current research in this field (see Freeman & Garety, 2004; Beards & Fisher, 2014). Participants also noted differences between the impact of physical, verbal

and cyber bullying. Researching the psychological impact of various forms of bullying would help to identify if these result in different beliefs, feelings, defences or outcomes.

Considering the systemic issues raised by participants; future research could focus on the barriers teachers may face in response to bullying reports, or effectiveness of current anti-bullying approaches. Furthermore, research would be helpful in EIP clinical staff teams to establish if they ask about bullying or see it to be relevant when working with individuals. This might help to inform areas in which staff training could be targeted.

Given the difference between given definitions of bullying and the nature of the accounts including incidents of trauma and abuse, further research exploring the construct of bullying is recommended. It may also be helpful to review measurement tools in the field of bullying as those based upon the traditional construct may be missing these more severe forms.

It is recommended that research exploring childhood abuse or childhood adverse experiences pays more attention to bullying as an individual construct (rather than grouping within other adversity) as the participants stressed the importance of the topic for young people. CSA research within EIP populations should distinguish between CSA and PSA as they may be experienced in very different ways.

Reflective Account

Undertaking this research project has been an incredibly rewarding process. I feel privileged to have been able to immerse myself in a project reflecting such important issues for a group of young people. I have also overcome many academic challenges as a novice IPA researcher which I can now reflect on with pride.

The topic of bullying was far more distressing than I imagined, leading me to question my own preconceptions. I was also surprised to hear very little about cyber-bullying, perhaps preconceiving this as a prominent issue for adolescent society. When participants disclosed traumatic events, I felt myself questioning ethical issues around the role of researchers in this context, a role that felt very different to that of a clinician. Some participants said it was the first time they had shared their story with anyone; I wondered what this was like for them as I was someone who they didn't know and would not ever see again.

I was left feeling shocked at the neglectful responses to serious physical and sexual assaults in school. Whilst I sadly have come across similar stories in my clinical work, I was not expecting the extent to which teachers and the school system seemed complicit in bullying and had, even if unwittingly, contributed to such distress. I was also left feeling helpless when bullying experiences were being missed by clinicians as I was not involved with their care. I was curious of what participants' perceptions of the final project might be and felt inherently aware that it is unlikely to be able meet such widescale hopes of reform. However, this reflection helps me feel more committed to dissemination.

I realised through the analysis process that I was very attached to participant accounts. I spent considerable time and effort immersing myself in the interview recordings and transcripts and later really struggled to cut down themes and direct quotes. I also found it difficult to write a coherent theme structure and narrative around experiences that were, by their nature, so fragmented. I think these issues were driven by a worry of silencing the participants as they had been silenced by so many others.

I also noticed during the analysis that I had distanced myself emotionally from some of these experiences, exploring them in quite a practical and logical manner. When one of

my supervisors described a participant experience as ‘harrowing’, I thought about how true this was. It helped me to notice I had perhaps protected myself from fully connecting to the levels of vulnerability and emotional distress of a group of young people who I had no role in helping.

Overall, whilst recognising the limitations outlined in the discussion, I believe this research offers a valuable contribution to the literature and is highly relevant and applicable to clinical work. I have noticed my own clinical skills develop through carrying out the project and holding the findings in mind. For example, I am more aware of the wider impact of social power, the various threats that patients may have experienced prior to their entry into services and how these issues might impact therapeutic or service engagement. I am also more curious in sessions about the systemic influences on patients and how these influence their ability to trust within their own relationships and with wider authority figures (e.g. work supervisors, college or university staff). Furthermore, it has encouraged me to ensure that I fully explore experiences of bullying and the impact and meaning of these on current identity and self-worth.

Conclusions

The findings have highlighted that bullying can play a role in experiences of psychosis. What is striking is the accounts of bullying were highly distressing, rather than a common developmental experience. Participants considered bullying to be highly relevant to their current mental health, especially paranoia experiences. They wanted them to be better considered by clinicians, particularly when first entering services. The findings also demonstrated phenomenological similarities between bullying history and the content of, or the nature of psychosis experiences which supports wider literature. Whilst remaining cautious of links to aetiology research, such findings may support the view that

life events may be implicated in psychosis. It is therefore argued that more attention is paid to bullying within trauma and abuse paradigms.

Furthermore, the findings demonstrate the impact of the wider systemic context on young people and their ability to seek and engage with help. Given the tendency of bullying to occur during the adolescent stage, it is particularly important for EIP services to have an awareness of its potential impact. Also, it is pertinent for the environments around young people to be aware of the damaging social discourses around difference which may lead to alienation and exclusion of vulnerable individuals in the first place.

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Appendix A

Reviews – Bullying and Psychosis

Table 1

Previous reviews exploring the relationship between bullying and psychosis

Author	Design	Aim	Included Papers / Study Samples	Summary of findings
Van Dam et al. (2012)	Meta-analysis	To investigate whether childhood bullying is related to the development of psychotic symptoms.	10 general population studies 4 'clinical' studies - defined as 'at least one contact with a mental-health service' (3 still drawn from population and cohort studies, only 1 from a clinical service)	Non-clinical studies identified evidence of an association between childhood bullying and 'non-clinical psychotic symptoms'. Increased frequency and severity and longer duration of being bullied led to stronger associations. Clinical studies failed to offer consistent support for a relationship between bullying and psychosis. Evidence was 'inconclusive' and warranted further research. Meta-analysis (of 7 population based studies) yielded unadjusted and adjusted odds ratios (ORs) of 2.7 [95% confidence interval (CI) 2.1–3.6] and 2.3 (95% CI 1.5–3.4) respectively.
Cunningham, Hoy and Shannon (2016)	Meta-analysis	To examine whether bullying is a predictor of psychosis through exploring prospective research designs	10 studies (4 of which used data from the Avon Longitudinal Study of Parents and Children (ALSPAC) and were therefore combined. All included studies were general population / cohort studies.	The authors concluded that bullying 'appears to cause later development of psychosis'. Meta-analysis yielded an unadjusted odds ratio (OR) of 2.148 [95% confidence interval (CI) 1.140–4.044].
Jack and Egan (2017)	Descriptive data synthesis	To systematically review the literature that concerns the association between childhood bullying and paranoid thinking.	11 studies (unpublished studies included). 8 studies from non-clinical (population, school or undergraduate student samples) 3 studies included clinical samples (2 were psychosis-related/UHR services)	Studies suggested a positive association between childhood bullying and paranoid thinking. The review highlighted various methodological weaknesses which limit these conclusions (e.g. self-report tools and inconsistent measures)

Appendix B

Systematic Review Search

Table 1

Literature search terms and results

	Search Terms *(Search date: 5 August 2018)*	**Results** *(CINAHL Complete, MEDLINE with Full Text, PsycINFO and PsycARTICLES)*
1	bully* or peer-victimi#ation or victimi#ation or victimi#ed or cyber-bull* or cyberbull* or bullied or "peer aggression" or "peer violence"	80,563
2	"adverse childhood experiences" or "early-life adversities" or "childhood adversities"	4990
3	Psychosis or paranoi* or psychoses or schiz* or psychotic or "hearing voices" or delusion* or "unusual experiences" or hallucinat* OR "mental illness*" or EIP or "Early Intervention Psychosis" or FEP or "First Episode Psychosis"	727,505
	1 AND 3	1477
	2 AND 3	634
	(1 OR 2) AND 3	2,111

Table 2

Systematic review inclusion and exclusion criteria

Inclusion Criteria	**Justification**
1. Qualitative, quantitative or mixed methods 2. Participants accessing any mental-health services (inpatient or outpatient, primary secondary or tertiary) 3. Bullying experiences (using study definition), occurring in childhood (defined as under 18) 4. Studies reporting relationship between at least one measure related to bullying and one measure related to psychosis, even if this was not primary aim (if quant). Psychosis defined to include psychosis-like symptoms or experiences, hearing voices and formally diagnosed psychosis disorders) 5. Studies making explicit reference to experiences of childhood bullying and psychosis experiences, even if this was not the primary aim (qualitative or quantitative)	1. To consider all methodologies as research base limited 2. To identify clinical populations 3. Focus of review 4. Focus of review. To identify articles where primary aim was not bullying (e.g. childhood adversity) but still contained findings relevant to review. 5. Focus of review. To identify articles where primary aim was not bullying (e.g. childhood adversity) but still contained findings relevant to review.
Exclusion Criteria	Justification
1. If psychosis outcomes are combined with other mental health outcomes. 2. If bullying outcomes are combined with other forms of victimisation. 3. Participants recruited from general population, school samples, learning disability or autism populations. 4. If psychosis symptoms reported to be organic or from medical conditions. 5. If bullying occurred in adulthood (over 18) 6. If bullying type was not relevant to research question (e.g. workplace bullying, sibling bullying)	1. Unable to draw conclusions about psychosis 2. Unable to draw conclusions about bullying 3. Focus of review is psychosis clinical sample 4. Not relevant to focus of review 5. Not relevant to focus of review 6. Not relevant to focus of review

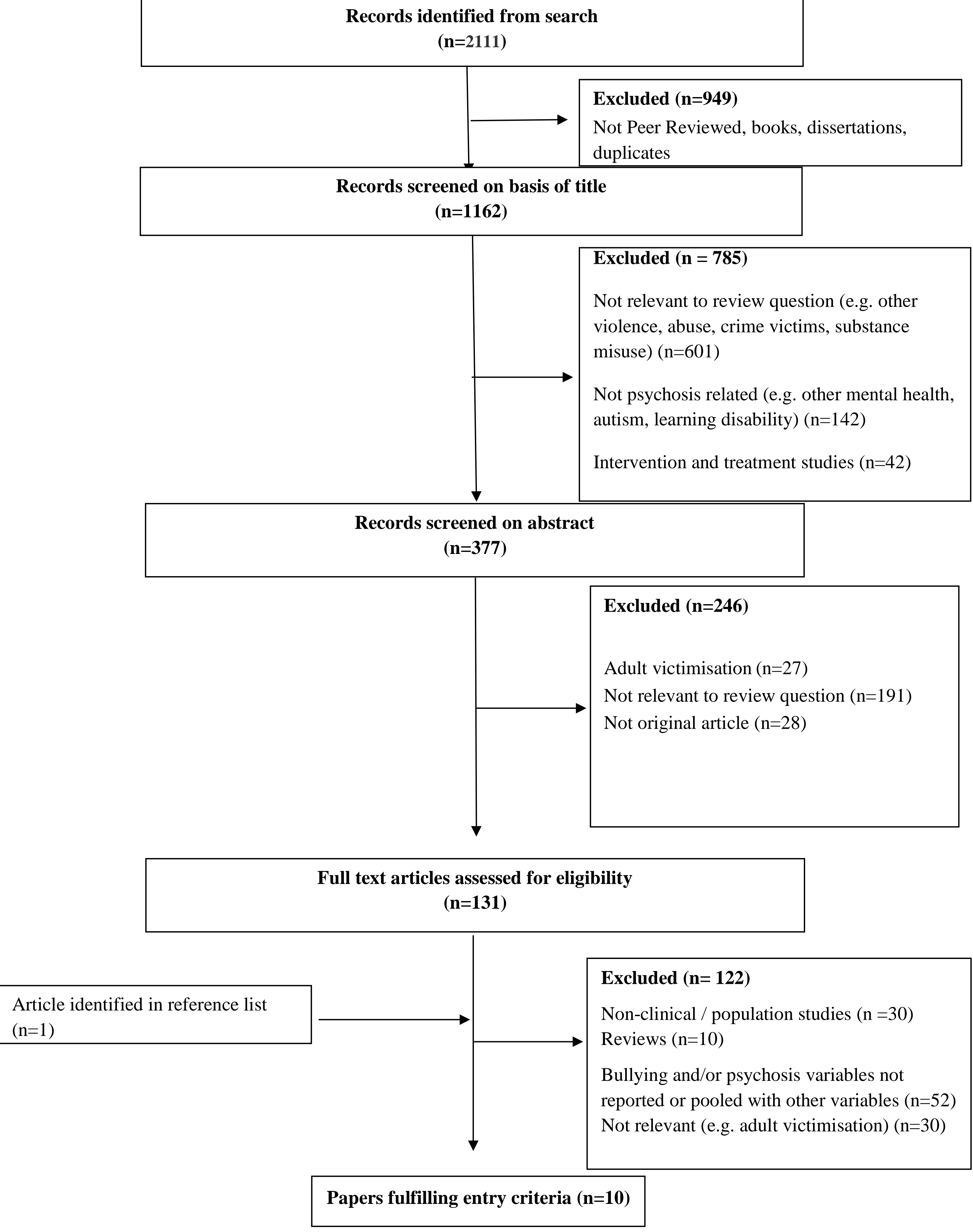


Figure 1: Search Strategy

Appendix C

Systematic Review: Study Characteristics

Table 1

Papers included in review

Author	Study Aim	Sample (N)	Mean Age	Clinical Group	Bullying Measure	Psychosis Measure	Key Results (relevant to review aim)
Correlational Studies							
Bird et al. (2017) UK	Do negative social experiences predict persistence of paranoia in young people?	34 (6 M, 28 F)	14.9	Community CAMHS, EIP and inpatient.	Cyber Victim &Bullying Scale (CBVS) (Cetin et al., 2011) Multi-Dimensional Peer Victimisation Scale (MPVS) (Mynard & Joseph, 2000)	Green Paranoid Thoughts Scale (GPTS) (Green et al., 2008) Positive and Negative Syndrome Scale (PANSS) (Kay et al., 1987)	Peer Bullying (r = 0.59, p<0.001) and cyber-victimisation (r = 0.39 p<0.001) significantly predicted paranoia persistence with medium to large effect sizes
Catone et al. (2017) Italy	1) Assess psychotic like experiences (PLEs) in adolescents seeking help 2) Assess association of PLEs with bullying	50 (24 M, 26 F)	14.2	Complex unit of Child and Adolescent neuropsychiatry, screened for 'psychotic-like experiences'.	MPVS	Adolescent Psychotic Like Symptom Screener (APSS) (Kelleher et al., 2011) Specific Psychotic Experiences Questionnaire (SPEQ)	Total bullying correlated with paranoia (r = 0.537, p<0.01), auditory verbal hallucinations (r=0.29, p<0.01) and negative symptoms (r=0.336, p<0.05).

						(Ronald et al., 2014)	
Luukonen et al. (2010) Finland	To investigate the association of bullying behaviour with psychiatric disorders and physical health in a sample of adolescent psychiatric patients	508 (208 M 300 F)	15.5	Psychiatric Adolescent Ward	Schedule for Affective Disorder and Schizophrenia Present and Lifetime) (K-SADS-PL)-Social Relationships Section	K-SADS-PL (Ambrosnini 2000)	No significant association found between psychotic disorders and bullying behaviour.
Masillo et al (2016) Italy	To investigate whether a particular personality trait called interpersonal sensitivity may be related to suspiciousness in those who experienced bullying victimization.	147 (74 M, 73 F)	17	Community Mental Health Services	Have you experienced either psychological bullying or physical bullying at least once in your life (yes/no)	Prodromal Questionnaire (screening) Structured Interview for Psychosis-risk Syndromes (SIPS) (Miller et al., 2003)	Bullying was a significant independent predictor of subtle suspiciousness–persecutory ideation* (β = .25, P < .01) *This is a term used interchangeably with paranoia (Miller et al., 2003)
McDonnell et al (2017) UK	To examine the potential mediating effect of interpersonal sensitivity in explaining the link between childhood bullying victimisation and real-time paranoid ideation in adult participants at clinical high risk for psychosis	64 (38 M, 26 F)	22.5	Community service for patients at CHR of developing psychosis.	Retrospective Bullying Questionnaire (RBQ) (Schafer et al., 2004).	State Social Paranoia Scale (SSPS) Virtual Reality Study	CHR patients reported high rates of bullying victimisation CHR patients reported high levels of paranoid ideation in a Virtual Reality environment. Severe bullying predicted interpersonal sensitivity which, in turn statistically predicted state paranoid ideation. (standardised β = 0.334, p = 0.013) but there was no significant direct effect. No significant direct or indirect effects were identified between

							frequency of bullying and paranoid ideation.
Case-Control Studies							
Lindgren et al. (2017) Finland	To explore childhood experiences and their influence on clinical symptoms (anxiety, manic, and obsessive-compulsive symptoms, positive psychotic symptoms)	122 75 clinical (49 M 26 F) 51 control (34 M, 17 F)	26.4 (FEP) 26.9 (control)	First Episode Psychosis (FEP) patients (aged 18-40)	Were you bullied at school? (yes/no)	The Brief Psychiatric Rating Scale (BPRS) (Overall & Gorham, 1962)	Statistically higher reports of bullying in FEP group (44.9%) compared with control (24.5%), p = 0.023
O'Connor et al (2017) Ireland	To explore whether: 1) perceptual abnormalities are more prevalent in co-morbid psychiatric diagnoses, 2) perceptual abnormalities are more prevalent in histories of childhood adversity (childhood trauma, bullying) 3) perceptual abnormality type is associated with co-morbid psychiatric diagnoses or histories of childhood adversity.	118 (51 M, 67 F) clinical 59 control 59	18.3	Ultra-High Risk (UHR) Clinic	Determined from history recorded in clinical file (yes/no)	CAARMS criteria (Yung et al., 2005) Operational Criteria for Psychotic Illness (OPCRIT) (McGuffin, Farmer & Harvey, 1991)	Childhood bullying was associated with significantly increased odds of reporting any hallucination (OR 5.00, P = .01). Results remained significant when auditory, visual and other hallucinations controlled for separately (OR 6.94, P = .01; OR 8.17, P = .004; OR 5.11, P = .02). No association found between childhood bullying and content of hallucinatory experiences.
Trotta et al. (2013) UK	To examine whether bullying was more prevalent amongst individuals presenting to services for the first time with a psychotic	437	28.4	Inpatient units (aged 16-65) presenting with FEP	Question on Brief Life Events schedule adapted from	Symptom data using the SCAN (WHO, 1994)	Psychosis cases were approximately twice as likely to report experiences of childhood bullying

	disorder than in unaffected community controls.	clinical 222 (134 M, 88F) control 215 (115 M, 100F)			Bebbington et al. (2004) (yes/no) (only included if bullying occurred over 5 years ago)	OPCRIT Psychosis Screening Questionnaire (PSQ) (Bebbington and Nayani, 1995).	victimisation (p<0.001) than controls even after adjustment for other life events. Significant associations were found between bullying victimisation and psychosis regardless of whether individuals had used cannabis or not. Higher prevalence of bullying victimisation found amongst patients with schizophrenia spectrum (p<0.001)
Valmaggia et al., (2015) UK	To examine whether a history of bullying would be associated with more paranoid ideation in CHR patients than healthy controls	64 (38 M, 26 F)	22.5	Community service for patients at CHR of developing psychosis.	Retrospective Bullying Questionnaire (RBQ) (Schafer et al., 2004).	State Social Paranoia Scale (SSPS)	66.7 % of UHR participants reported bullying victimisation, compared with 25.6 % of healthy controls (OR = 5.19, p=0.005) 40 % of UHR and 14% controls reported bullying in primary school (OR = 4.22, p=0.005) 53% of UHR and 19% controls reported bullying in secondary school (OR = 4.96, p<0.001)
Mixed Model							
MCatone et al. (2016) Italy	To detect whether there is a thematic link between past experiences and delusion content	16 (9 M, 7 F)	13.4	Child and Adolescent Psychiatry Unit (Referred for psychotic symptoms and diagnosed with psychotic disorder)	n/a	n/a	Persecutory delusions were found to be significantly associated with humiliating experiences (phi coefficient, 0.7; *p* = .004)

Appendix D

Initial Bullying Questionnaire

The following questions are about experiences of bullying. Each question below will ask you to specify whether the experience happened in primary school (ages 4-11), Secondary school (ages 11-18), or in the community (e.g. neighbourhood, sports groups, activity clubs). The questions are not asking about experiences within the family or home environment.

1. These questions are about physical forms of bullying. This means hitting and kicking, being locked in a room, or having your property stolen or damaged. Did you experience any of these things? (please tick all that apply)

	Primary School	*Secondary School*	*Community*
Hit/Kicked			
Locked in a room			
Belongings damaged/stolen			

For 'community', please state age and setting……………………………………………………………………..

2. The next questions are about verbal forms of bullying. This means being called nasty names or other hurtful things, and being threatened. Did you experience these things? (please tick all that apply)

	Primary School	*Secondary School*	*Community*
Called names/hurtful things			
Threatened			

For 'community', please state age and setting…………………………………………………………………..

3. The next questions are about indirect forms of bullying. This means lies or nasty rumours told about you, or being ignored or left out of things on purpose. This also means receiving upsetting messages through social media, the Internet or by text. Did you experience any of these things? (please tick all that apply)

	Primary School	*Secondary School*	*Community*
Had lies/rumours spread about you			
You were ignored/left out of things			
They posted something online about you			
You received upsetting messages			

For 'community', please state age and setting……………………………………………………………………..
For messages/cyberbullying please state media (e.g. Instagram)………………...

4. What were the main things that bullies said about you (e.g. names you were called)?

……

5. Did you experience any other forms of bullying that were not mentioned above? Yes / No

If yes, please state……………………………………………………………………………………………

6. In Primary School:

How often did you experience bullying (in any of the above ways)?

Less than once a month	*Once or twice a month*	*Once a week*	*Several times a week*	*Everyday*

7. In Secondary School:

How often did you experience bullying (in any of the above ways)?

Less than once a month	*Once or twice a month*	*Once a week*	*Several times a week*	*Everyday*

8. In the Community (e.g. sports clubs/ neighbourhood)

How often did you experience bullying (in any of the above ways)?

Less than once a month	*Once or twice a month*	*Once a week*	*Several times a week*	*Everyday*

9. **In total**, how long did your experiences of bullying go on for? (no. of weeks? years?)

………

10. Where would you consider the bullying experience to have been the **most** serious

Primary School *Secondary School* *Community*

11. Who were you **mostly** bullied by?

One boy *A group of boys* *One girl* *A group of girls* *Both boys and girls*

12. How serious would you consider your experiences **overall**?

Not at all *Only a bit* *Quite serious* *Extremely serious*

13. Are you still experiencing any of the bullying now? *Yes / No*

If yes, please state type and context……………………………………………………………………

Appendix E

Interview Schedule

"Thank you for taking part in this research study. These questions are to guide us in a discussion about your experiences of bullying, such as what it means to you and how it might have impacted you. Learning about your experiences in more detail will help us to understand them better and be able to think about what might be helpful for others with a similar experience. The meeting will be recorded so that I can use accurate stories in the next stage of the research (analysis). All the recordings will be transcribed, and transcripts will be anonymised so that you can't be identified. If, however you tell me something in which yourself or another person might be at risk of any harm, then I would need to share this to be able to keep you, or others safe. There is no pressure to talk about anything that you find too difficult and please let me know if at any time you would like to stop. If you would like a break at any point please also let me know. Do you have any questions before we start?"

1. Firstly, what would you say the word 'bullying' means? What does it mean to you?

2. Can you think back to when you were first bullied and tell me more about this?

   Prompts…what was a typical day like? Did your experience change at all over time? Can you tell me more about any other experiences?

3. Can you tell me what it was like to have the experiences?

   Prompts…How did you feel? How did you respond?

4. Did you share your experience of bullying with anyone?
   a. If so can you tell me more about this?
   b. If not, why do you think this was?

5. Do you think anything would be different now if you hadn't had these experiences?

6. Can you tell me more about the reasons you (or your family) wanted help from this service?

   Prompts…What's a typical day like for you now?

   (If unusual experiences reported - How do you understand these?)

7. Looking back over your experiences, what would be helpful for others to know?

   Prompts… What do you wish others had known? Is there anything wish you had known earlier?

8. Is there anything we haven't discussed that you think is relevant?

Appendix F

Ethical approval

15/01/18

Dear Claire Wheeler,

Letter of access for research

As the holder of an existing NHS honorary clinical contract you do not require an additional honorary research contract with the NHS Foundation Trust. We are satisfied that such checks as are necessary have been carried out by your employer. This letter confirms your right of access to conduct research through the NHS Foundation Trust for the purpose and on the terms and conditions set out below. This right of access commences on 15/01/18 and ends on 01/09/18 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct activities associated with such projects as you have received authorisation confirmed in writing from the Research and Development Director of the NHS Foundation Trust. Please note that you cannot start the research until the Chief Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to the NHS Foundation Trust premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this Trust, in particular that of an employee.

While undertaking research through the NHS Foundation Trust, you will remain accountable to your employer NHS Trust but you are required to follow the reasonable instructions of your nominated manager in this Trust or those given on her behalf in relation to the terms of this right of access.

You must act in accordance with the NHS Foundation Trust policies and procedures, which are available to you upon request, and the Research Governance Framework.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer NHS Trust is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

You are required to co-operate with the [redacted] NHS Foundation Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on [redacted] NHS Foundation Trust premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998.

Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

The [redacted] Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by the [redacted] NHS Foundation Trust in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

Please also ensure that while on the premises you wear your NHS ID badge at all times, or are able to prove your identity if challenged. Please note that this Trust accepts no responsibility for damage to or loss of personal property.

If your circumstances change in relation to your health, criminal record, professional registration or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform your employer through its normal procedures. You must also inform the Research and Development Department and your nominated manager in [redacted] NHS Foundation Trust.

Yours sincerely

Deputy Director of Research and Development,

[redacted] NHS Foundation Trust

Email: hra.approval@nhs.net

20 December 2017

Dear Miss Wheeler,

Letter of HRA Approval

Study title:	**Childhood Bullying: Perceptions of individuals who access services for First Episode Psychosis (FEP)**
IRAS project ID:	**229173**
Protocol number:	**N/A**
REC reference:	**17/EE/0436**
Sponsor	**University of Essex**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

IRAS project ID	229173

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from the HRA website.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document *"After Ethical Review – guidance for sponsors and investigators"*, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the HRA website, and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the HRA website.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found through IRAS.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application

IRAS project ID	229173

procedure. If you wish to make your views known please use the feedback form available on the HRA website.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details on the HRA website.

Your IRAS project ID is **229173**. Please quote this on all correspondence.

Yours sincerely,

[redacted]
Senior Assessor

Email: hra.approval@nhs.net

Copy to: [redacted] *Sponsor Contact*
[redacted] *NHS Foundation Trust, Lead R&D Contact*

Appendix G

Participant Information Sheet (PIS)

Research Project: Childhood Bullying: Perceptions of individuals who access services for First Episode Psychosis

This study has been reviewed by an NHS ethics committee (IRAS ID: 229173) to ensure that the rights, safety, dignity and well-being of everyone that takes part in this study are protected.

Chief Investigator

Claire Wheeler – Trainee Clinical Psychologist, School of Health and Human Sciences, University of Essex, Colchester, CO4 3SQ.

Supervised by:

Lecturer in Clinical Psychology, School of Health and Human Sciences, University of Essex, Colchester, CO4 3SQ.

Introduction

I would like to invite you to take part in a project which is about bullying in childhood. The reason I am interested in bullying is because it is something that is experienced by many people, particularly in childhood. Also, there is not much research that helps us really understand people's experiences or how bullying might impact their lives. Bullying is usually thought of as when one person has continuously hurt or humiliated another person or has constantly left them out on purpose. You may have your own definition for bullying which I would be interested to hear about.

Why am I doing the project?

I am a Trainee Clinical Psychologist and the project is for a Thesis at Essex University. I am hoping that the results will help others (e.g. staff in health services, schools, families) to understand the experience of bullying for young people. If others are more aware of people's stories, they might be able to think in new ways of how they can respond to them.

What will you have to do if you agree to take part?

Either contact me directly (details provided below) or if you prefer, we can arrange a meeting through your Care Coordinator.

1. We can first arrange a time to meet, which is convenient for you where I will explain more about the study and you will have a chance to ask any questions.
2. There will be one, single meeting with myself during which I will first ask you some brief questions about the types of bullying you experienced (e.g. verbal, cyber, physical) and how frequent this was. I will then ask broader questions about your experience. This might involve asking about how school was for you, or how others (e.g. school / family/friends) responded if you shared your bullying experience.

How much of your time will it involve?

You might first want to meet me briefly to find out more about the study (approx. 10 minutes). The main meeting will last 45-60mins. We will then allow 10 minutes at the end to have some time to think about how you found taking part in the study and any questions you might want to ask me. You will also be offered an optional debrief for another time if you wish to discuss it any further.

Is it confidential?

I will not have access to any of your medical records. If you agree to take part, your story will be kept anonymously, and your name will not be given in the results or to anyone else. The discussion will be audio-recorded just so that I can make sure I have an accurate recording of your story; the recordings will only be listened to by myself, they will also be deleted from the recording device and stored on a secure drive at Essex University that only I can access. The recording will all be typed up by me, using a name that is different from yours so that you can't be identified. The research team (my supervisors) will also have access to the anonymous data. Every effort will be made to anonymise any direct quotes used in the write up of the study although due to the nature of quotations, anonymity can never be fully guaranteed. The only time I might need to share our discussion with someone is if you tell me anything that means that you or someone else is at risk of harm. I would then talk about this with your care co-coordinator who might need to share it to keep yourself safe. If this happened, I would make every effort to tell you first.

What are the advantages of taking part?

You may find the project interesting and like the opportunity to help other people's understanding of what bullying might be like for some individuals. You will be offered £10 in cash to say thank you for giving up your time.

Are there any disadvantages of taking part?

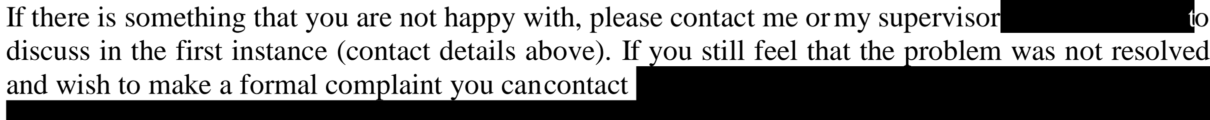
It is possible that discussing some bullying experiences may make you feel upset. I will help to make you feel comfortable and you don't need to tell me about anything that is too upsetting. After the session, you will be given appropriate contact details if you need more support. You will also be offered a further session to talk over the study if you think you would like this.

Do you have to take part in the study?

No, you do not have to participate. This study is separate from your treatment with the service and so it won't impact it at all. Also, if you start the study but change your mind, you can ask to stop without giving any reason. Data collected up to the point of withdrawal will not be retained for use in the study.

What if there is a problem?

If there is something that you are not happy with, please contact me or my supervisor to discuss in the first instance (contact details above). If you still feel that the problem was not resolved and wish to make a formal complaint you can contact



If you wish to access confidential independent advice, you can talk to the Patient Advice and Liaison Service (PALS) on 0800 0857935

What happens now?

If you are interested in taking part, please contact me on If you prefer, you can complete a tear off slip below and post it in the box provided in the reception area. Your Care Co-ordinator can help with getting in touch.

Appendix H

Recruitment Flier

AN INVITATION TO TAKE PART IN A RESEARCH STUDY: Childhood Bullying

What is the project about?

Many young people talk about situations where another person has intended to injure, humiliate or exclude them on purpose. This might be in person or over social media.

This project aims to find out more about experiences of bullying. This is to help improve understanding and develop ways of supporting people.

What will it involve?

I will contact you to tell you more and give you a chance to ask any questions.

We will meet in person for 45-60 minutes. There will be a brief questionnaire and then we will discuss your experiences.

It will be anonymous, so your name or personal details will not be included in any of the results. You will also be able to withdraw from the study at any time.

How can I take part? If you are aged 14-35 years old and experienced any form of bullying, you may be able to take part. You will receive £10 in cash to thank you for your time.

You can arrange a meeting through your Care Coordinator or text 'RESEARCH' to

Aged 14-35?

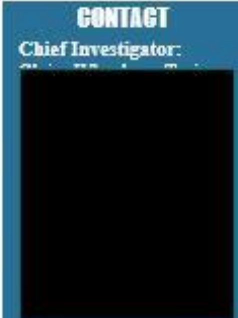
Contribute to research to help others understand young people's experiences

One-to-one meeting

You will be offered £10 cash to say thank you for your time

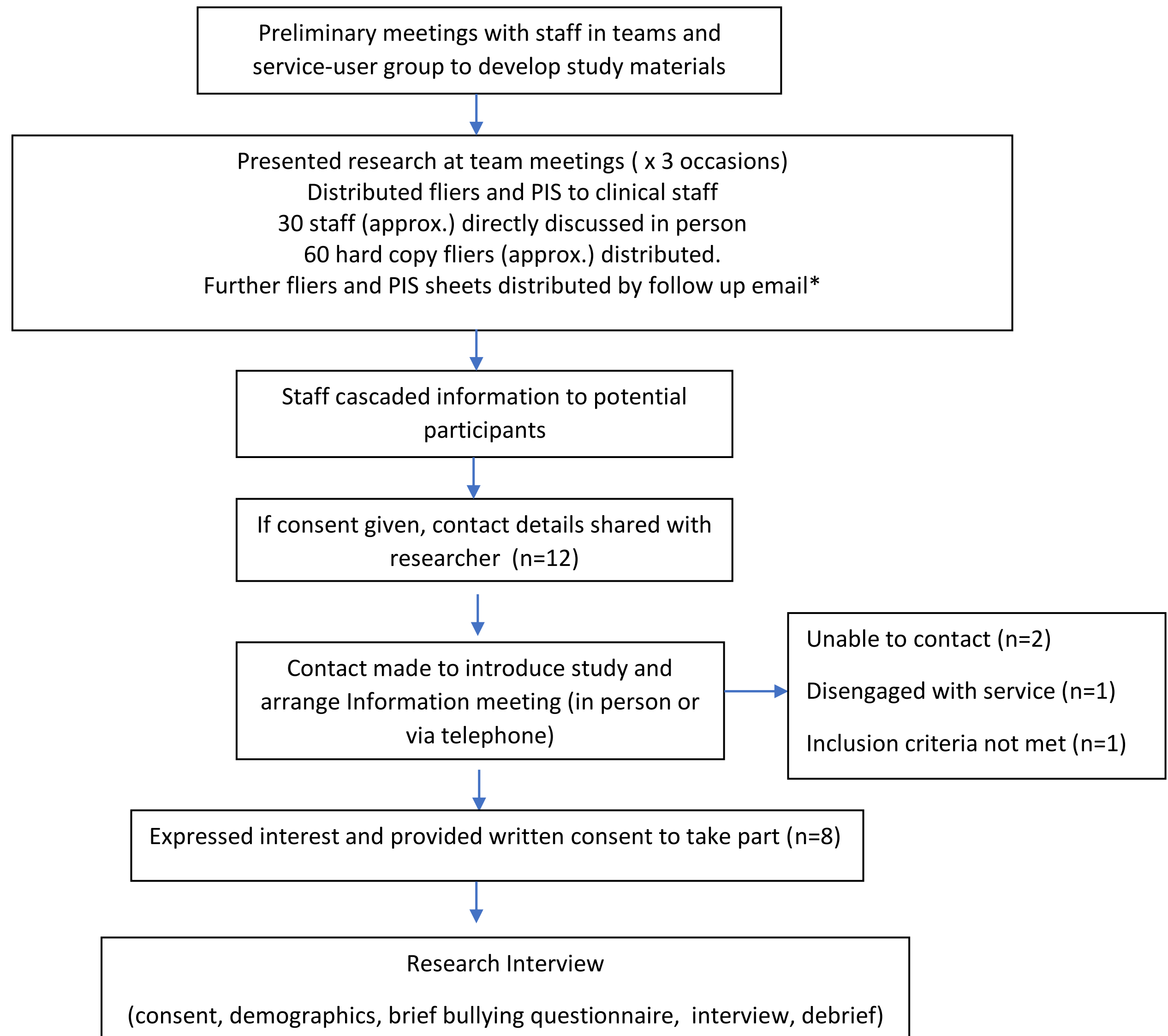
CONTACT

Chief Investigator:



Appendix I

Recruitment Flow Chart



*numbers are estimated as several visits were made to each team. Also due to electronic distribution exact distribution totals are unknown.

Figure 1: Flow chart to show recruitment process

Appendix J

Transcript Analysis Extract

Emerging Themes	Transcript	Exploratory Comments
	I: When you first remember those initial comments, can you remember how it felt?	
Process of questioning Repression	**P:** I do remember feeling a bit hurt by them. I was like, "Why would she say things like that?" I was, obviously, pretty small and I didn't understand. I did feel upset by them, I remember, but I wasn't initially that upset, because I tended to ignore. I ignored it initially, but then I do remember I had never experienced it. I didn't really know what it was and just real sad, but I didn't know what to do with it. I just kept it to myself and that was about it. Then, obviously, again later on when it just got out of hand it was a different level of upset still not understanding why it's happening to me.	Confusion – why me, what is this? How do I deal with it?? Small – young- lacking awareness/ knowledge – more vulnerable? Recalls some emotions but able to 'contain'. Not knowing what to do with it. Repressed -internalised until 'out of hand' – escalation
	I: Can you say a bit more about that, that time as it changed or what changed?	
Loneliness Social comparison Flawed self Avoidance	**P:** What happened was it progressed into, obviously, she didn't like me initially and she took away my best friend then and eventually it was just like everyone was against me. I just felt like the loneliest little girl in the world. I just thought no one likes me. I have no friends. I remember sitting out at playtime on the bench, it was cold and freezing, by myself and watching them play in the distance. I just remember thinking there is something wrong with me because they didn't want to play with me. I always thought there was something wrong with me. I just remember wanting to cry. I cried a lot in the toilets. Just by myself. I remember wanting playtime to be over just, so I could be in the classroom. Obviously, you had a seating plan so you just sat next to whoever. That was it. You don't really have to talk to anyone so it was cool, so I just remember playtime being the worst thing I used to hate. I just used to skip out on lunches because I used to hate sitting alone. Lunch time I	*'in the world'* -global extent of loneliness Feeling disliked Watching others – did she desperately want to be a part of that? 'Distance' from what her own experience was? *Cold and freezing* – can't find warmth in others? Concluding – there must be something wrong with me Wanting to avoid feelings of loneliness.

Loneliness (unbearable) Flawed self	just used to not eat my lunch. I used to just run to the bathroom and try and hide. I just remember it being a very lonely experience, and just being scared of what's going to happen next. I just really thought I was to get in trouble as well. I just really thought there was something wrong with me, that I was doing something wrong. Again, it's just a weird space to be in especially at a young age.	Playtime – exposed to threats Loneliness unbearable – depriving self of basic needs (food)? Fear Flawed Self? *Weird space – hard to put words to?*
Teacher complicit Panic Punished, blamed Facing injustice Questioning self Teacher complicit Flawed self	**I:** I'm wondering what did you think you'd get in trouble for? **P:** My school was a really small school and what the girls would do, there was this teacher. It was the main bullies, I think. They would always run to her, they're like, "She has been doing this. She said this to me. She is being like this to me." And like, "she did this to me. She hurt me." It was a lot of lies told to that teacher. That teacher, obviously, she believed the large group of girls and I was being punished for it by her. I remember not liking this teacher, because even to this day I just get really, I don't know how to explain it, this weird panicky sensation from it, even talking about it. We're talking about her because even when things were being said she still treated me like I was a horrible bully. She could see that I was alone. It'd be simple things like if we were on the dinner line she'd always send me to the back even if I wasn't doing anything. I remember this one incident where I literally just told someone, "Could you move up a bit?" We were on the carpet and I told her to move up. She called out my name in this really disgusted tone I remember. It was just like, "I heard that you're quite a bully." It was like, "What did I do?" and I just think she was just awful. If I needed help with anything she just never wanted to help me with anything [pause]. She, I know she didn't like me. It was just that as well. I thought there was genuinely something wrong with me, because I just thought, "Oh my God, the teacher thinks I'm really bad." I used to be really quiet and I never used to be saying anything. Then I just remember every time she used to come in and have a class I used to really hate it. I had a horrible time with her.	Teacher complicit in bullying behaviour Impact on her still present today Connects emotively with panic bodily sensations when recalling memory She could see my vulnerability why didn't she help me? Recalls the tone – disgusted – did she start to view herself as disgusting? Facing unjust accusations -being labelled as the bully when being bullied – what was this like? Teacher – never helped Rejected at time of need? If the teacher thinks I'm bad (position of authority, adult)– I must be bad?

Process of questioning Mistrust Impact on future help-seeking	**I:** So when she said 'you're quite the bully', can you remember how that felt to hear that? **P:** It was literally like someone had shot me. I couldn't explain it. I didn't know what bullying was then. I knew that bullying was wrong, that was the thing. You just knew something was wrong. I just didn't understand why she was being mean to me. I was like, "I wasn't doing anything." Like literally told someone to move up, and I was like 8 and she is a grown woman. The fact that she would be like, "You're a bully." I'm like well I'm being bullied but I'm not the bully. It was just weird because then I knew. I remember specifically thinking I can't trust anyone. I felt, "Oh my God if *she* thinks I'm a bully. I definitely can't tell anyone anything."	*Shot me – quick sharp pain, end of life* Confused – didn't know what it was, knew wasn't doing it, just knew it was wrong. Mistrust Impact on help seeking in future- I won't be believed, people will think I'm the bully
Attacks on self-worth Withdrawing Fearing consequences Helplessness	**I:** And did you tell anyone anything after? **P:** The way my mom and my family found out I was being bullied was girls used to leave little messages in my drawer and then it was things like, "you're a horrible person, no one likes you. You're annoying." I think there was this one particular horrible one that I just took home. This was in year five, I think. I just didn't know what to do with it. It was just really horrible one. I don't fully remember what it said. It was just something like, "You should leave. You should go away. No one likes you." I think I slept with it for like a week under my pillow. I carried it everywhere and I read it over and over. I think my sister, I think I left it one morning and she was making the bed and then she read it. She was just like, she just said, "What is this?". Then, it was always marked as anonymous, but obviously I knew who it was. My sister was like, "What's going on?", I think my sister had some inkling in that something was going on because I think I was a bit more quiet. Then I just remember her talking to me going, "We're going to sort it out." Then I *really* also didn't want her to go in and sort it out. I was worried about it getting worse and no one believing me. I remember when she came I had to wait to be picked up after school by my sister and she came a bit later than usual. It was just me left in the classroom. It was my sister and her best	*Found out* – had tried to keep it hidden Others attacking her – unlikeable, annoying, horrible – impact on self-worth? Do written words in a note make words even more prominent? Harder to forget, able to re-read? Why did she become so attached to reading note over? What impact did this have? Leave / go away/ not wanted Others noticed changes in character / actions Becoming quiet, withdrawing from others? Sister concerned – wanted to help but she was worried about being believed /worsening

Defining Bullying False friendships Feeling blamed/shamed Impact on future help-seeking	friend and my Year 5 teacher. My Year 5 teacher was always someone, he made it clear that he had a clear policy against bullying. And even throughout that time I still wasn't convinced that I was being bullied. I didn't [pause] really think it. But, obviously, my sister did think it and she came in and she showed the letter. **I:** Sorry did you say you weren't convinced or he.. **P:** I wasn't convinced. I don't think I had the concept. I knew of it, but I didn't really know what it was. I remember my sister just talking to my teacher and handed over the letter and he was reading it. I'm sure he was like, "What the hell? This is going on in my classroom." I remember the day after it, the girls, they tried their best to be my friend because, obviously, they were all in trouble and there was a whole looking into who wrote that. I don't think it ever got solved. But I remember they then accused me of writing that letter and that's when I just thought, "This has made it worse." **I:** You say they accused you? **P:** One of the teachers, when they were trying to make out who had written the letter, she said, "We think you've written the letter for some attention." I was like, "No."	Stuck? Want help but fearful of consequences Concept of bullying – what is it? How is it defined? How does she know if she is being 'bullied? *How we use and understand language and terms – weighing up if we 'fit' a concept, can know the word but not what it is* Attempts at friendship weren't genuine Teacher responded, took action – moment of hope. Brief changes- but quickly turned back on her. How did this leave her feeling about help? The person with strongest policy can't stop it – felt to blame. Other's assuming need for 'attention'
Mistrust Feeling blamed / shamed	**I:** How did that feel? **P:** It was horrible. It was years of bullying anyway and year five was the worst year of it and then you have this horrible letter and then to be told that you'd written it for yourself was just like someone was stabbing me. It's just that whole thing of trust and someone who should know better that didn't know better. I just felt like I was in the wrong throughout that whole thing when really, I wasn't. I just didn't like it, so I was just like, "OK just, please, forget about the letter. I just don't care about it anymore, they've said sorry", which they did but,	Mistrust in those who are meant to protect - Feeling blamed? Shamed? Stabbing - harsh, painful, continuous - previously used 'shot' – both severe expressions of hurt False forced apologies - meaningless

School culture of neglect Feeling blamed / shamed Unheard	obviously, they said sorry because they didn't, I mean they weren't actually sorry. They just didn't want to get into trouble. It was a horrible thing. Especially when I think about them now, dealing with the teachers was probably worse than dealing with the actual girls. You are told, "Come and tell us if you're being bullied," but when I do you're not taken seriously, or you're not being believed. **I:** What would have been a good response, do you think? **P:** I think just to have a sit down with her and ask them what *really* was going on and not being so [pause]. They literally just focused on the letter part when it finally came to it, they just focused on the letter part. They didn't really ask about what I was going through, what had happened. I don't think they even acknowledged how long it was going on for either. It was just like I'm playing the victim, it almost feels like.	At the time felt in the wrong, only on reflection able to see she wasn't. Ingenuine responses – meaningless apologies Those who protect can't be trusted to help Let down, disempowered by system there to protect? Policies meaningless - School culture of neglect? Labelled as 'Playing the victim' Not believed, not asked – no interest in her story – really wants to be heard and validated
Mistrust Impact future help-seeking Feeling blamed / shamed	**I:** What was that like for you? **P:** Even now to this day I just feel like there is always a trust issue. If I have an issue, I will probably take the longest time if I do even come around to telling anyone that there's a problem. If I think there's something wrong, I still panic and I still have that same panic that I had when I was younger about I've done something wrong. I haven't done anything wrong but you still get it. You're still like, "I've done something wrong. I'm going to get told off for it." I think that stays with you.	*Reflecting on the impact to this day – is she surprised by this?* Mistrust – help seeking Connecting bodily experience of panic from now to then. Things 'stay with you'

Appendix K

Reflective Log Extract

Immediate reflections after Meeting 2

Ppt 2 was bubbly, chatty and it was easy to build general rapport with her. At the same time, I sensed some anxiety from her restlessness and many questions. She said she was feeling unsure about what to talk about as so much happened with her bullying. I realised here the value of having a questionnaire to get her started in thinking about experiences, although I also wonder if I could have done this naturally by just adding some more focused Qs at the start of interview.

She was keen to talk about her work in a theatre school, explaining how much of an achievement it was after not working / in education because of her struggles with mental health. I admired her pride in her achievement and wondered if she wanted me to know she was good at this, perhaps fearing I might see her otherwise? Was she also preparing for being under the spotlight, testing whether I might be a judging audience?

After my last consultation feedback, I aimed to let this ppt guide the interview fully and see where it took us. She often digressed away from the topic to current worries and her account was quite disjointed. It seemed like she was preoccupied with current worries and wanted my advice about them. Perhaps these early digressions were a defence against talking about more painful feelings. I noticed I didn't want her to feel she had done something wrong if I brought us back to topic, as I became increasingly aware of her low self-esteem.

I noticed myself feeling angry at her teachers for not helping her, less so towards the bullies. How did no one do anything? She was well supported by her family, but the school seemed to be the most powerful force in this story. She described an accident at age 5 when she broke her nose and teachers 'patched her up and sent her back to class' and perhaps if there was tarmac instead of concrete, she would have had a 'softer landing'…perhaps an analogy of her wider experiences?

I was intrigued by her passion and desire to share so much information for the research. She is so passionate about wanting change for others being bullied and clearly has hopes that my project would do this. I am left feeling unsure if I can ever meet her expectations and worried that I will be yet another person who just 'patches her up' and sends her on her way.