THE UNIVERSITY OF HULL

Exploring psychological distress in the lives of those affected by homelessness

being a Thesis submitted in partial fulfilment of the requirements for the degree
of

Doctor of Clinical Psychology

in the University of Hull

by

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May 2021

Acknowledgements

Firstly, I would like to thank the individuals who took part in this research and entrusted me with their stories. Thank you for putting your faith in me to amplify your voices, I feel truly privileged. Without you, this research would not exist.

To my supervisors, Dr Anjula Gupta and Dr Chris Sanderson, thank you for your unwavering support and encouragement. Thank you for believing in me and providing much needed containment during supervision sessions - I could not have done this without you both.

I would like to also express my gratitude to Kelly Finnis, for your enthusiasm for the research study, and for facilitating recruitment. Thank you to Sally Acton and Sue Gearing for responding to my countless emails and for your continual support to recruit participants. I am truly grateful for your support and you have been an integral part of the project, particularly during the pandemic.

Finally, thank you to those closest to me. To my friends, thank you for always believing in me and cheering me on. To my wonderful partner, Doug, thank you for your unconditional love and support throughout this journey, and for providing me with endless cups of tea whilst I worked.

To my mum, thank you for always having faith in me, even when I struggled to have faith in myself. Thank you for being my role model for independence, hard work and determination. Thank you for doing everything possible to make sure I had best opportunities to achieve my dreams. Thank you for letting me make my own choices, and for supporting me in them. It is because of you that I am here today, submitting my thesis to become a Doctor of Clinical Psychology.

Overview

This portfolio thesis is comprised of three parts and considers the experience of homelessness and psychological distress, from the perspectives of those with lived experience.

Part one: Systematic Literature Review

Part one contains a systematic literature review which explores the influences on homeless service users' experience and perception of mental health services. A systematic search of six data bases retrieved ten suitable papers, the findings of which are presented using narrative synthesis. Three overarching influencing factors and ten sub-factors emerged. Conclusions and clinical implications for service development are discussed.

Part two : Empirical paper

Part two is a qualitative empirical study which explored how previously homeless White British males make sense of distressing unusual experiences and beliefs, by hearing their stories. A narrative oriented inquiry framework applied four analytic perspectives to analyse the stories' content, form and identity positions. Conclusions and implications for practice are considered.

Part three: Appendices

Part three consists of the appendices supporting both previous parts. A reflective and epistemological statement is included.

Total Word Count: 24,007
(excluding references and appendices)

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Clinical Psychology Review

Please see Appendix C for submission guidelines

Word Count: 11,504
(excluding references)

Homeless service users' experiences and perspectives of mental health services: A Systematic Literature Review

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Abstract

Purpose

Homeless service users face barriers when accessing mental health services, despite having a high need for support. Understanding service user perspectives is vital when attempting to improve service quality and accessibility. This review synthesises the influences on homeless service users' experience and perception of mental health services.

Method

A systematic literature search was applied to six databases. The search identified 263 papers, 10 of which met the inclusion criteria. Narrative synthesis was applied to the extracted data.

Results

Narrative synthesis resulted in three factors that influenced homeless service users' experiences and perceptions. The first factor was the nature of services, which included rigid vs flexible service approaches, accessing and navigating services and the physical environment. The second factor was the impact of the service involvement which involved meeting practical needs, acquiring diagnostic labels, changing feelings and development of identity and sense of self. The final factor was relationships with services, which included the approach and qualities of service staff, the staff-service user relationship and other service users.

Conclusions

This review demonstrates important considerations for service development. Services that were flexible, easily accessible, choice-driven, and non-judgemental promoted personal agency and fostered positive relationships.

Key Words: homeless, mental health, services, perspectives, experiences

Introduction

Research suggests that homeless service users find it particularly hard to access and engage with mental health services, despite 80% of homeless people in England reporting a mental health issue in 2014, with 45% given a specific diagnosis (Homeless Link, 2014). Despite homeless individuals having one of the highest mental health needs, research by St Mungo's suggests that only 26% of homelessness professionals thought that rough sleepers in their local area were able to access mental health services (Glew & Orchard, 2016). The report identified various systemic barriers to mental health support for homeless individuals: the requirement of a General Practitioner (GP) referral preventing street outreach professionals from referring; difficulties registering with a GP due to no fixed address; their ability to attend mental health appointments was dependent upon finding a suitable sleeping location nearby; and co-occurring substance abuse needs being identified as the 'primary need' by mental health professionals, resulting in the denial of mental health support.

International policies have prioritised meeting the mental health needs of individuals facing homelessness and housing instability, citing a need for systems change and multi-agency working (Brackertz, Wilkinson & Davison, 2018; Mental Health Commission of Canada, 2012). The World Health Organisation's Comprehensive Mental Health Action Plan (Saxena & Setoya, 2013) highlights the need to address disparities in access to mental health care for vulnerable or 'at risk' communities, including individuals who are homeless. It suggested a proactive strategy involving the identification of barriers, assessment of needs and staff training, in order to develop services that meet the needs of these communities. In the UK, the NHS Mental Health Implementation Plan was published (NHS England, 2019). This reported that by 2023/24, 20 high-need areas in the UK will have established specialist mental health provision for rough sleepers, with £30million of central NHS funding allocated for this purpose. The plan proposed a trauma-informed service approach, and aimed to integrate existing homeless outreach, accommodation and physical healthcare services. The plan stated that all areas should ensure that their mental health services are accessible to people who rough sleep. It is essential for existing literature in this area to be consulted, which may inform the development of new and existing mental health services that are accessible and effective at supporting homeless individuals.

The introduction of the ‘Recovery Model’ within mental health services encouraged service users to be viewed as active participants as opposed to passive recipients of mental health care, of which service user involvement became an integral part of (Allott, Loganathan, & Fulford, 2002, p. 14). Specific national and international policies provide guidance on how to integrate service user involvement into healthcare provision (NHS England, 2017; Coulter, Parsons, Askham & World Health Organization, 2008). Service user perspectives provide a rich resource of expert-by-experience knowledge, which can highlight differences in the priorities of professionals and service users and suggest new ways of thinking, to ensure care is truly person-centred and facilitative of recovery (Tait & Lester, 2005; (Clark, Glasby & Lester, 2004). The Strategies for Living Project undertaken by the Mental Health Foundation (Faulkner, 2000) explored the perspectives and priorities of those who use services in the UK. The report highlighted the role and value of acceptance, relationships to others, shared experiences and identities, finding meaning and purpose, taking control, having choices and security and safety.

A service user perspective can play a key role in the evaluation of current services and may highlight barriers to accessing or engaging in care. A previous literature review exploring service user experiences of mental health care emphasised the importance of building positive interpersonal relationships with service providers and the continuity of care (Newman, O'Reilly, Lee & Kennedy, 2015). One review explored access to mental health services for what the authors termed ‘hard to reach’ groups - of which homelessness was deemed one of (Lamb, Bower, Rogers, Dowrick, & Gask, 2012). Constructing groups of people as ‘hard to reach’ can be criticised and may place the blame for service inaccessibility on the very people who require such services. It has been suggested that such labels reflect communicators’ frustration in trying to reach people unlike themselves, in terms of power and privilege (Freimuth & Mettger, 1990).It appears that it may be the services that are in fact ‘hard to reach’ (Bucci, et al., 2019) due to multiple organisational and systemic factors. This review identified practical and logistical constraints that formed a barrier to accessing mental health care, such as transport difficulty, housing instability, lack of time, perceptions of ineligibility and a lack of understanding on how to navigate the system. Additional powerful barriers related to service user beliefs about the appropriateness of using health care systems to address difficulties seen as originating from adverse social conditions. Findings indicated a reluctance of service users to understand their problems as mental health problems due to a perceived threat to their identities. This resulted in dissonance and communication difficulties between professionals’ models of mental health difficulties, and individual sense making of their issues. This was suggested to result in the perception that mental health professionals were unable or unwilling to elicit and understand individuals’ own sense-making – deterring help seeking and service engagement.

Previous systematic literature reviews of homeless service user perspectives on healthcare have focused on: the experience of specialist mental health supported accommodation (inclusive of but not limited to those who had experienced homelessness; Krotofil, McPherson & Killaspy, 2018); effective substance use treatment (Carver, Ring, Miler &

Parkes, 2020); the acceptability of a range of health and social interventions (Magwood, et al., 2019); accessibility of sexual health/reproductive healthcare (Paisi et al., 2020); primary healthcare needs and experiences (Dawson & Jackson, 2013) and palliative care provision (Hudson, Flemming, Shulman & Candy, 2016). One paper has previously attempted to collate existing literature on homeless service users' perceptions on mental health services and the adequacy of care (Bhui, Shanahan & Harding, 2006). However, in addition to now being out-dated, the review portion of the paper was not a robust, systematic literature review. The papers collated from the review were only discussed in the context of the simultaneously presented empirical study findings. Therefore, the article can be considered to be primarily an empirical study rather than a systematic literature review.

There appears to be a gap in the literature for a current systematic literature review which collates and synthesises literature exploring the experiences and perceptions of homeless service users on mental health services. The proposed review aims to fill this gap and explore the influences that shape service users' perceptions and experiences. This may inform the development of mental health provision for homeless individuals, increasing the likelihood of a positive and helpful experience of mental health services. This review asks the following question:

What influences homeless service users' experience and perception of mental health services?

Method

The guidance issued by the Preferred Reporting Items for Systematic Reviews and Meta Analyses (PRISMA) informed the writing of this review (Moher, Liberati, Tetzlaff, Altman & Prisma Group, 2009).

Search Strategy

Multiple data bases were searched to increase the likelihood of obtaining all relevant articles to answer the review question. The systematic searching strategy was applied to six electronic data bases, five of which were accessed through EBSCO Host: Academic Search Premier, Psycinfo, MEDLINE, PsycArticles and CINAHL Complete. The Web of Science platform was also utilised to access the Core Collection. The search was completed initially in September 2020, and repeated in March 2021 to ensure recent papers were also captured.

Search terms

Search terms were identified through scoping searches of the literature in the area, and through reading previous reviews of similar topics and noting the keywords in the subject area. The search terms were discussed with two research supervisors and additional synonyms were considered and added to develop the final search terms. The search terms were specified to occur within the ‘Title’ of papers, as their previous application to ‘All’ and ‘Abstract’ resulted in many irrelevant papers being returned. A limiter of ‘English’ was applied during the search protocol, to ensure papers could be read and understood by the researcher.

“homeless*” OR "rough sleep*" OR "sofa surf*" OR roofless* OR unsheltered OR unhomed OR unhoused

AND

“mental health” OR “mental* ill*” OR “mental wellbeing” OR “mental disorder” OR “psychiatric illness” OR “psychological wellbeing” OR “psychological health” OR “psychological illness*”

AND

perceive* OR perception* OR attitude* or opinion* or belie* OR understand* OR view* OR misconception* OR point N3 view OR expectation* OR experience OR engage*

NOT

child* OR minor

Selection Strategy

Duplicate papers were identified and removed during paper screening. The remaining papers were then screened by Title and Abstract against the inclusion and exclusion criteria, detailed in Table 1. These criteria were developed through discussion with the research supervisors. The full papers were then accessed, read and the inclusion and exclusion criteria applied to determine eligibility and relevance to the review question. Figure 1 demonstrates the process of paper selection.

Table 1.

Paper inclusion and exclusion criteria and rationale

Inclusion Criteria	**Rationale**
Available in English	Necessary to be read and understood
Qualitative Design (or Mixed Methods with Qualitative Component)	The review question is interested in experiences and perceptions of services, and therefore rich, qualitative data is most suited to answer the question
Peer Reviewed	Improving the likelihood of obtaining high quality studies

Exclusion Criteria	**Rationale**
Non-English Language	Cannot be read and understood by the researcher
Not Peer-Reviewed	Cannot ensure the quality of the study
Literature Review/Correspondence	This review aims to review and synthesis original research
Quantitative only design	Unsuitable to provide the level of deep insight needed to answer the research question
Insufficient focus on perceptions of mental health services	The review question is focused specifically on the experiences and perceptions of mental health services, rather than services more generally
Child participant sample (Under 18)	Child mental health services are often structured and managed differently to Adult services, and so this was necessary to ensure some level of homogeneity amongst papers
Studies focusing on non-service user perspectives	The review question is focused specifically on the experiences and perceptions of service users
Conference Posters	Posters provide insufficient data to be included in a systematic literature review, and may not be peer-reviewed to ensure quality

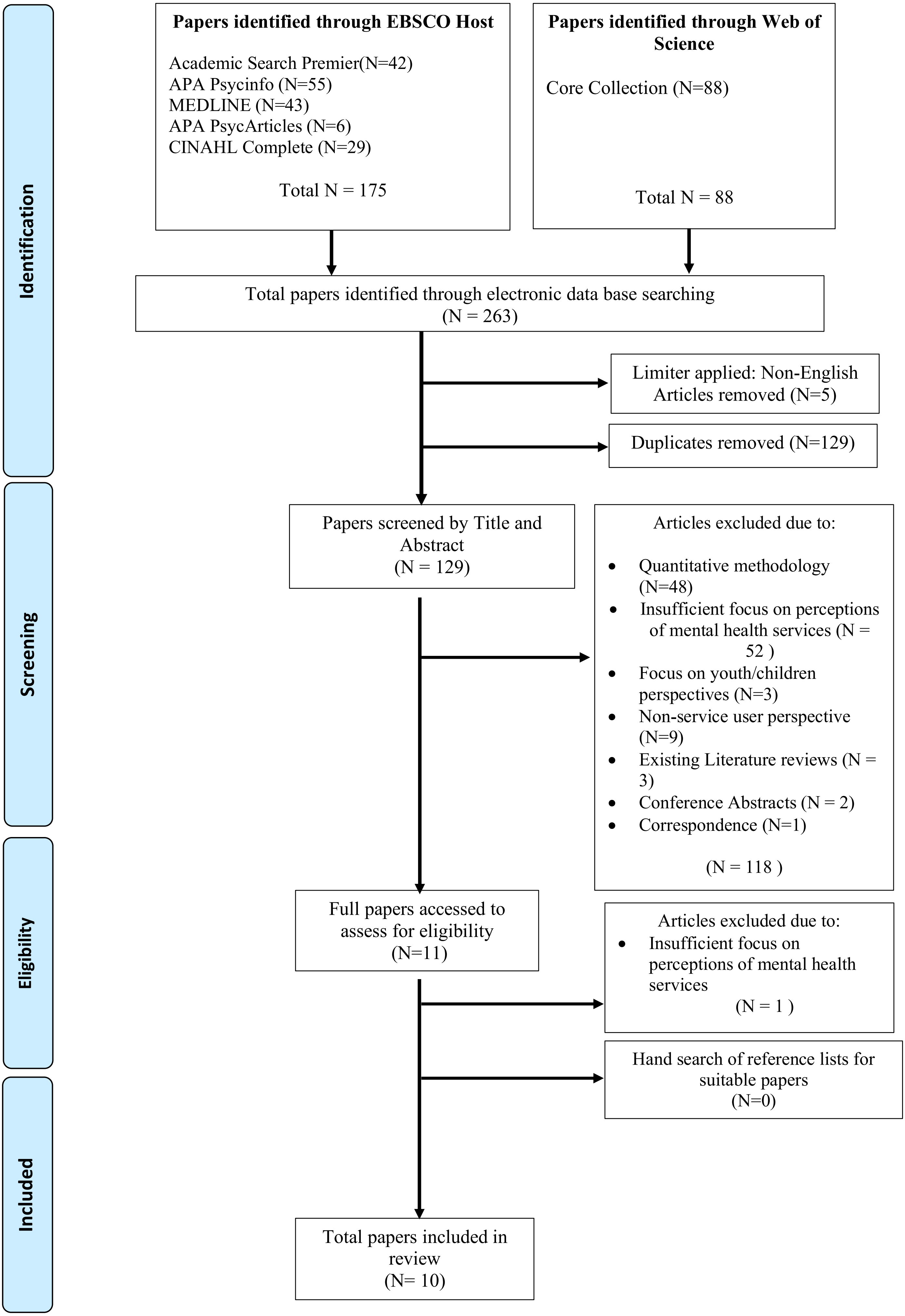


Figure 1. The paper selection process based on PRISMA guidelines (Moher et al., 2009)

Data Extraction and Quality Assessment

Data was extracted using a data extraction form (See Appendix D), which collected information from each paper on aspects relevant to answer the research question, such as study aims, participants, methodology and key findings. The quality of each paper was assessed using the National Institute for Health and Care Excellence (NICE) quality appraisal checklist for qualitative studies (NICE, 2012) (See Appendix E). This checklist assesses 14 aspects of qualitative research, with each aspect rated on a 3-point scale, culminating in one of three overall quality assessment ratings. The various ratings are: '++' (all or most of the checklist criteria have been fulfilled, and where they have not been, the conclusions are very unlikely to alter); '+' (some of the checklist criteria have been fulfilled, but where they have not been, the conclusions are unlikely to alter) and '-' (few or no checklist criteria have been fulfilled and the conclusions are likely to alter). This quality checklist was selected due to its detailed guidance and example notes to accompany the checklist, which resulted in a broad and thorough consideration of various quality components within each study. Three studies were additionally assessed and rated by another researcher to establish inter-rater reliability. Disagreements were discussed until checklist criteria and a final rating were agreed upon.

Data Analysis

Narrative synthesis was used to analyse the extracted data, in the hope of telling a trustworthy story of the literature exploring homeless service users' perceptions and experiences of mental health services (Popay et al., 2006). Narrative synthesis was chosen due to its textual approach to synthesis, which was felt to maximise service user voices, aligning with the overarching purpose of the review. The included studies also utilised different qualitative methodologies and had a large range of sample sizes, rendering other specialist synthesis approaches unsuitable. Tabulation and repeated reading of the extracted data was used to conduct a preliminary synthesis of the findings, which led to the clustering of conceptually similar findings. From here, an inductive approach was taken to allow factors and sub-factors to emerge from clustered findings. The consideration of relationships between these factors was explored and discussed with research supervisors. The final factors and sub-factors were discussed agreed upon in research supervision to maximise methodological rigour.

Researcher Position

The narrative synthesis findings and the interpretations made within the review will undoubtedly have been shaped by the position of the author. The author was a White-British female, who was employed as a Trainee Clinical Psychologist in the UK. The author held values of person-centred care, social justice, equality, and the importance of the amplification of marginalised voices within research and service planning. The author partook in reflexive interviewing within research supervision and reflective journaling, to gain awareness of assumptions, biases, and values, and consider how this could potentially affect the review. It was hoped that this would increase the transparency and rigour throughout the process of data interpretation and synthesis.

Results

Overview of studies

Ten papers were included in this review, which were published in the time range 2006 – 2019, although no time limiter was applied in the search. (see Appendix G for key characteristics of studies). Most papers had qualitative methodologies. One paper used a mixed methods approach, and so only the qualitative component was used for the purpose of the review, which was focused on experiences and perceptions. Two of the papers used the same large data set (Huey, Fthenos, & Hryniewicz, 2012; Huey, Fthenos, & Hryniewicz,

2013) but the studies utilised distinct analytic procedures, resulting in different interpretations informed by the different research questions. Sample sizes ranged from 10 – 79 service users, with one study unclearly reporting how many service users took part (Watson, 2012). Participants were solely service users for most of the studies, but for two studies, staff perspectives were also included (O'Reilly, Taylor, & Vostanis, 2009); Watson, 2012). For these two studies, it was deemed possible to disentangle the voice of service users from staff members, and so only the service user perspectives were used in the synthesis of findings for this review.

The studies reported on the perspectives and experiences of service users regarding a range of different types of mental health services, including inpatient, supported living in hostels and community services (See Appendix G). Some papers explored experiences of broader health and social care services (Kerman, Gran-Ruaz, Lawrence, & Sylvestre , 2019; Bhui et al., 2006), but there was deemed to be a sufficient component of mental health service experiences to be relevant to the review question. There were a range of qualitative methodologies utilised, which are detailed in Appendix G. The studies took place in various locations across the United Kingdom, Australia, the United States of America, and Canada.

Quality of studies

Quality assessment resulted in seven studies being graded as '++', meaning that all or most of the checklist criteria were fulfilled, and where they have not been, the conclusions were very unlikely to be affected (NICE, 2012). Three studies were graded as '+', meaning that some of the checklist criteria were fulfilled, but where they were not or had been inadequately reported, conclusions were unlikely to alter. Appendix F demonstrates a more detailed breakdown of each study and specific checklist item ratings.

In general, papers appeared to have a strong rationale for the use of a qualitative approach, and where necessary, justifications were made for the use of specific qualitative methodologies, which appeared appropriate to the research aims. Detailed descriptions of the sample and sampling method were observed across papers, apart from one paper, where it was unclear how many service users in total took part (Watson, 2012). The context surrounding the research and participants was clearly described amongst papers.

Papers differed on their transparent explanations of data analysis procedures. Some provided detailed descriptions of their analysis procedures, enhancing transparency and replicability of studies. Three studies (Darbyshire, Muir-Cochrane, Fereday, Jureidini & Drummond, 2006; O'Reilly et al., 2006; Watson, 2012) did not provide adequate detail on their analysis procedures, which made it difficult to see how themes and concepts were derived from the data. The same papers were also unclear on how they had implemented reliability checks (i.e., multiple coders).

Qualitative research emphasises the key role of the researcher in influencing data collection, selection, and interpretation of research (Finlay, 2016). A common weakness across papers was the absence of the reflexive position of the researcher. This made it difficult to understand the researcher's role in shaping the research findings and to consider potential sources of bias. This meant that the trustworthiness of conclusions was difficult to ascertain, and may have compromised the overall transparency, rigour and thus quality of the papers included in the synthesis. As such, caution should be taken during the secondary interpretation of data within the narrative synthesis' findings.

The reporting of ethical considerations and procedures lacked detail across papers, although most did report the approval of an ethics board.

Narrative Synthesis

Three overarching factors appeared to influence homeless service users' experiences and perceptions of mental health services. Table 2 highlights these factors, with subsequent sub-factors.

Table 2.

Overview of influencing factors and sub-factors

Overarching Factors	Sub-factors
The nature of services	1. Rigid vs flexible service approaches 2. Accessing and navigating services 3. Physical environment
Impact of service involvement upon the service user	1. Meeting practical needs 2. Acquiring diagnostic labels 3. Changing feelings 4. Development of identity and sense of self
Relationships within services	1. The approach and qualities of service staff 2. Experience of the staff-service user relationship 3. Other service users

The nature of services

This factor explores how the nature and features of services themselves can shape the experience and perceptions of service users. It considers the influence of a service's approach and philosophy; their organisational rules, access policies and systems; and the physical environment of a service.

Rigid vs Flexible service approaches

The nature of the rules and policies held and enforced by services had important implications for the service user experience.

Service users described strict, rigid and authoritarian approaches contributing to a negative experience within services, and such approaches appeared to reduce the likelihood of continued service engagement (Padgett, Henwood, Abrams & Davis, 2008; Kerman et al., 2019; Bhui et al., 2006; Watson, 2012.). Strict substance abstinence requirements were experienced as a barrier to service engagement and therefore obtaining mental health support (Padgett, et al., 2008; Watson, 2012):

> *"They said they were afraid that I was drinking too much. They take people with problems, so I don't know why they turned me down. It was the same with the four other places I went to" (Padgett et al., 2008, p. 229).*

Other rules and restrictions experienced negatively by service users were medication requirements; mandatory attendance at treatment groups; signing over disability payments and close supervision and curfews within residential mental health support settings – one service user described this as "like jail" (Padgett et al., 2008, p. 230). Service bans or refusals were experienced as one sided by service users, and therefore perceived as unfair and discriminatory, leading to feelings of hopelessness and abandonment. One service user discusses the impact of this regarding their self-worth:

> *"You feel like you have nobody and nobody wants to help you…What is wrong with me that the shelter can't even take me?" (Kerman et al., 2019, p. 779).*

One paper explored experiences of a specific model of service delivery – “Continuum of Care (CoC)” or “Treatment First” (Watson, 2012). This model was conceptualised as resulting in “Structural Chaos”, due to the rigid focus on service participation and substance abuse abstinence in return for housing. Resulting themes identified that CoC services were perceived as limiting service users’ individual agency, given the lack of control service users had over their own lives. Service users described themselves as feeling they lacked a voice and were powerless due to the rules:

> *“[The first program I stayed at] was just very very structured and, I felt, punitive. And I didn’t like the model [it used]. Because if you didn’t fit in with what they expected you to do, or be, it was difficult…And I feel that I’ve gone through a lot in life, but I’ve never felt powerless…[It]was almost like if you didn’t agree you had to be quiet” (Watson, 2012, p. 335).*

Service users also described resentment of mandated interventions such as group therapy or counselling. They were perceived to be a waste of their time, felt they had lost control and had been forced to be emotionally vulnerable (Huey et al., 2012). Some service users described actively thwarting the process of mandated counselling by avoiding discussions of trauma with service staff or “bringing up the past” (Huey et al., 2013, p. 314).

In contrast, service users viewed flexible service provision with reasonable policies, minimal hierarchies, and opportunities for choice positively (Kerman et al., 2019; Watson, 2012; Huey et al., 2013; Taylor, Stuttaford, Broad, & Vostanis, 2007). Flexible service hours (Huey et al., 2013), opportunities for additional telephone support or extra appointments during times of crisis (Taylor et al., 2007), choice of appointment location and outreach services

(Kerman et al., 2019) were appreciated and contributed to a positive perception of services. Services that helped them despite intoxication or being at full capacity were perceived as compassionate and understanding (Kerman et al., 2019).

These service features were perceived positively by service users and allowed them to manage the demands of their complex situations more easily, enhancing the likelihood of continued engagement. For example, service hours beyond 5pm meant that service users could attend to more pressing, higher priority issues during business hours with other agencies, such as homelessness or financial issues, whilst still engaging in mental health support if needed (Huey et al., 2013). In this way, the experience and perception of mental health services is influenced by not only the service's provision of adequate mental health support, but its ability to fit in with current life commitments and more immediate goals.

Service users also explained how choice in the services they engaged in resulted in the services becoming more meaningful to their lives. Choice and agency allowed ownership of their accomplishments, resulting in positive influences on their sense of self:

> *"They're giving you the chance to make up your mind…They're back there to help me, but I have to make the first steps by myself. It makes me feel like that I'm doing it on my own…that sort of brings pride into it cause you're doing it on your own" (Watson, 2012, p.337).*

The same paper that explored CoC support programs (Watson, 2012), also explored experiences of an alternative service model – "Housing First" – which in contrast, does not demand abstinence or engagement in specific treatments, and instead promotes choice and flexible support options. Service users spoke of how such approaches gave them a sense of security and stability in their lives, as opposed to continual worry and fear about loss of housing:

> *"…That's scary when your housing is tied to your ability to remain abstinent. I mean you live kind of in a constant fear, you know what I mean. One fuck up and I'm homeless…It's not conducive to remaining sober with that kind of pressure […]it's a huge relief when you realise your housing is not tied to your ability to remain abstinent. Huge relief." (Watson, 2012, p. 339).*

Accessing and Navigating Services

Service users faced multiple barriers when accessing and navigating mental health services, which shaped their overall experience and perceptions of services. Service users explained limited awareness or knowledge about community services and how to access them, leading to feelings of being lost within service systems, and coming to rely on acute/emergency services (Kerman et al., 2019; Huey et al., 2012):

> *"I didn't know where to begin besides the hospital and I'm tired of the hospital now. I want to do something different. I think I'd rather go into outpatient meetings, but I don't know where to go" (Huey et al., 2012, p.128)*

Other barriers to accessing services involved lack of identification (Kerman et al., 2019), difficulties with transportation access and costs (Taylor et al., 2007; Darbyshire et al., 2006; Huey et al., 2012), affordability (Kerman et al., 2009), poor phone accessibility and inflexible opening hours (Bhui et al., 2006; Huey et al., 2012), all of which made it extremely difficult to make and attend appointments. A lack of communication between multiple agencies was also described, leading to experiences of care as dispersed and fragmented, and having to repeat one's story multiple times:

> *"It was like you had to re-explain your whole, entire friggin' story to them so, like, they didn't just send a crappy little referral" (Darbyshire et al., 2006, p. 558).*

Waiting times also negatively influenced service users' experience, which was commonly mentioned across papers. Service users described insufficient help at times of crisis due to the time it took to get an appointment, and stated that having a place to go at times of crisis is important for continual coping (Bhui et al., 2006). Negative perceptions of care were influenced by long waiting times and lack of sufficient face to face time (Kerman et al., 2019).

One solution to the difficulties with accessing and navigating services is integrated and 'in house' mental health services, which were frequently appreciated by service users across studies (Huey et al., 2013; Darbyshire et al., 2006, Taylor et al., 2007, Huey et al., 2012). Service users described the benefits of such services – they were able to access appointments quickly, felt more relaxed within their familiar environment, saved on transport costs and it helped those who were uncomfortable about leaving the hostel environment (Taylor et al., 2007). This provision was also perceived as having improved the awareness of the mental health support available to hostel residents, which facilitated knowledge and ease of access and subsequent referrals (Taylor et al., 2007). Service users also suggested fully integrated accommodation and mental health service provision would be beneficial, as a 'one stop shop' (p. 558):

> *"A youth shelter, but as a hospital, where they have people come in that need a bit of help with their thinking" (Darbyshire et al., 2006, p. 558).*

Physical Environment

The quality of the physical environment of the service provision also influenced service users' perceptions of services. Hospitals and crisis centres that were brightly lit, noisy and sometimes dangerous were perceived negatively by service users (Padgett et al., 2008). Poor quality, dirty 'live in' service environments with 'chaotic' and 'uncomfortable' atmospheres were also perceived negatively, and resulted in diminished feelings of self-worth (Kerman et al., 2019):

> *"There is still cockroaches everywhere. Nobody says anything, we don't matter" (Kerman et al., 2009, p. 780).*

In contrast, less clinical and 'formal' settings were valued by younger service users and helped them to feel more relaxed and comfortable (Taylor et al., 2007). Service environments which were quiet, clean, calm, safe and private were experienced positively and had calming effects for service users (Padgett et al., 2008; Kerman et al., 2019). Service users also appreciated green spaces when staying in psychiatric hospitals (Kerman et al., 2019; Padget et al., 2008)

> *"It looked like a kingdom…its like the trees and then the grounds and everything, they were like beautiful. I was like Oh my God! I've never seen a hospital like this" (Padgett et al., 2008, p.230).*

Service users also compared private service provisions to public/government funded services, which was possible as service users occasionally were still covered by their parents' private health insurance (Dabyshire et al., 2006). Public facilities were experienced as having poor food and lack of outdoor and recreational spaces, whereas private services had more opportunity for activities, outdoor space and better food available (Darbyshire et al., 2006):

> *"...outside you've got a nice gazebo to sit in, it's calming, you've got a craft room and the food is really nice, you go in there and you come out like 10 kilos extra." (Darbyshire et al., 2006, p. 557)*

One service user shared this disparity and sense of unfairness:

> *"Why is everything like, the government stuff is crap and the private stuff is good, like it shouldn't be like that for mental illness, why do they?" (Darbyshire et al., 2006, p. 557).*

Impact of service involvement upon the service user

This theme considers the perceived and actual impact of mental health services on the lives and journeys of homeless service users, from their perspective. Such outcomes inevitably influenced service users' overall experience and perception of mental health services. The impact of service involvement appeared to fall into four domains; meeting practical needs, acquiring diagnostic labels, changing feelings and development of identity and sense of self.

Meeting practical needs

The extent to which services were perceived as helping service users to meet their practical needs, influenced perceptions of mental health services. Given all service users had experience of homelessness or were currently homeless, an important tangible outcome of service involvement was receiving support to secure housing, get their basic needs met and therefore to follow a different life direction (Huey et al., 2013; Kerman et al., 2019; Taylor et al., 2007). This was done by offering integrated accommodation and mental health provision, or by supporting referrals to additional agencies and help navigating the system to acquire and maintain their housing. One service user perceived mandated therapy programs as beneficial only to regain permanent custody of her children (Huey et al., 2012).

Support to access other services through referrals, filling out forms and accompaniment to appointments was valued, as it made the process seem less daunting, and reduced the likelihood of missed appointments (Taylor et al., 2007; Kerman et al., 2019). It was experienced as helpful when services were knowledgeable about other services that may be able to help them and could assist them in navigating the system (Kerman et al., 2019). One participant discussed their mental health co-ordinator accompanying them to doctors' appointments, which also related to the 'Feelings' sub-theme due an increase in confidence:

> *"I wouldn't go to the doctor's on my own, I couldn't…and so she would come with me just to make sure, keep me at ease, allow me to know that it wasn't that bad, that I was all right and so she would just like keep reassuring me…That increased my confidence and made me able, like, to go to the doctors whenever now" (Taylor et al., 2007, p. 226).*

Negative experiences occurred when services failed to develop a detailed case history at assessment, which may have revealed trauma, and therefore were unable to provide information on potentially valuable organisations and services to service users (Huey et al., 2012). For some female service users, perceived outcomes of mental health service involvement were around a potential disruption to their time and energy required to spend focusing on higher priority needs, such as food, shelter and work (Huey et al., 2013).

Acquiring diagnostic labels

Service users spoke of the influence of the attachment of labels to themselves and their experiences. Some homeless women discussed how they had been either over diagnosed or misdiagnosed, without their previous life histories and current contexts or substance use being considered, which they felt closed down opportunities to make sense of experiences (Huey et al., 2012):

> *"They never asked me about my childhood, they just diagnosed me with depression, and if they was to hear about my childhood they would see why I was depressed" (Huey et al., 2012, p. 130)."*

Service users commonly discussed their perceptions of diagnostic labels; in their communities, having a mental health problem may be seen as negative, unacceptable and may be rejected by service users, which may inhibit service engagement and retention (O'Reilly et al., 2009). Service users perceived labelling – either behaviourally (e.g., troublemaker) or diagnostically (e.g., psychotic) as a 'shorthand' approach to understanding their problems, and felt it became an end in itself rather than a starting point (Darbyshire et al., 2009):

"I think they're just trying to label you – you know, the quicker we label them, the quicker we can get them on medication, the quicker we can get them out of here" (Darbyshire et al., 2006, p. 556).

Participants suggested how further perceived stigma generated by labelling may be unhelpful, given their already marginalised and stigmatised situation of being homeless.

Changing Feelings

The impact of service involvement on service users' feelings was discussed both positively and negatively, and influenced the overall experience and perception of mental health services. Positive changes to feelings as an outcome of mental health service involvement involved making sense of difficult feelings, re-arranging negative thinking, solving problems, increased confidence and feeling less alone when moving on to independent living (Taylor et al., 2007). Service users saw group therapy as an effective way to deal with feelings of isolation or shame due to traumatic events, with one woman saying, "It helped me break out of my shell" (Huey et al., 2012, p. 129). Some service users expressed feeling they mattered and feeling good about themselves as a positive outcome from their service experiences (Darbyshire et al., 2006; Kerman et al., 2019).

"She's helped me see in different ways. Instead of seeing the bad of everything, seeing the good things about life as well" (Taylor et al., 2007, p. 224)

For some service users, the mental health service community enhanced social ties, leading to feelings of belonging, 'camaraderie', feeling supported and connected to others (Pahwa, Yuan, Padgett & Smith, 2018). For these service users with weak social ties to the mainstream community and with no family members in their lives, they relied on the mental health service community for socialisation and reported developing strong bounds with staff (forming a link to 'Service Staff' sub-theme). Those with social ties primarily in the mental health community felt more comfortable here, due to the perceived stigma in mainstream communities.

Feelings appeared to be influenced by the service's organisational approach. Service users felt an increased sense of security and stability in their lives and a reduction in fear when partaking in Housing First services compared to CoC services, which then provided a sound basis for them to do additional mental health and substance abuse work, and the service was perceived overall as more favourable by homeless service users (Watson 2012).

Homeless women who perceived mental health counselling favourably reported outcomes of expressing difficult feelings which resulted in personal growth and helped them to let go and move on from traumatic events (Huey et al., 2013):

> *"I do talk about things that's going on with me because if I do hold it in, I have resentments. I let everything out, resentments and anger and all types of stuff within me. If I'm holding things in, (. . .) I'm not going to be the person I really want to [be] (. . .) as long as I got it out of me, I'm free" (Huey et al., 2013, p. 312).*

For some participants, service engagement was associated with perceived psychological and emotional risks, or negative feelings following service use. Homeless women discussed their distrust of counselling services, and their beliefs that therapy sessions involved a therapist forcing them to relive their trauma repeatedly without explicit benefit, and so they felt it would set back their personal recovery (Huey et al., 2012; Huey et al., 2013). As a result of these ideas, services were perceived as unhelpful and potentially emotionally damaging, preventing engagement:

> *"I don't get the point of counselling because why keep talking about it again and again? It's just going to make it worse (. . .) It's just going to sit on your brain" (Huey et al., 2013, p. 314).*

Some service users reported feeling their counselling did not address the root of their emotional difficulties due to a lack of trauma exploration (Huey et al., 2012). Other outcomes of being denied sufficient treatment were feelings of distrust and hopelessness, resulting in mental health worsening, negative perceptions of mental health services and avoidance of services in the future (Kerman et al., 2019).

Development of identity and sense of self

Mental health service involvement appeared to shape service users' identities and sense of self, which then influenced their perceptions and overall experience of mental health services, for better or for worse. For younger homeless service users, accessing mental health services presented an identity dilemma. Young homeless people perceived those with mental health issues as 'Nuts, Schiz, Psycho' and 'Crazy' (O'Reilly et al., 2009, p. 1740; Bhui et al., 2006, p. 158) and therefore found the prospect of being labelled as having a mental illness negative and unacceptable for their self-identities, which negatively influenced service engagement.

Receiving support from a mental health service but rejecting the identity of a ‘mental health service user’, therefore required participants to integrate this experience into their sense of self in an acceptable way. The way in which they did this, was to soften the role of the mental health coordinator by referring to them as a ‘counsellor’, which appeared to be more socially acceptable and was associated with less negative stigma. Service users distanced themselves from the term ‘mental health’ where possible:

“I ‘ad problems I didn’t ‘ave mental health problems”

“I’m not mental”

(O’Reilly et al., 2009, p. 1740, p. 1739)

Therefore, the perceived negative impact on services users’ identities as a result of mental health service involvement was managed by viewing the self as a person who ‘just needs somebody to talk to’ (O’Reilly et al., 2009, p. 1741), as opposed to someone who was ‘Nuts’ (p. 1740) , and so the overall perception of the service became socially acceptable to the service users.

Other service users discussed their developing identities as a person who mattered and needed support (Darbyshire et al., 2006) and as an individual rather than an illness (Watson, 2012), which were closely related to their experiences with professionals. The Housing First model and the power of service user choice allowed individuals to take ownership of their achievements and feel proud, and so had positive implications for service users’ sense of self (Watson, 2012).

In contrast, rigid service approaches had negative implications for service user's sense of self - being treated as 'their illness(es) first and individuals second' (Watson, 2012, p. 335) resulted in the self-perception of being a vulnerable, 'second class person'(Watson, 2012, p. 334) who lacks power, agency, autonomy and freedom, and who was defined by their substance use (Padgett et al., 2008; Darbyshire et al., 2006). Rules and restrictions impacting accessibility to services also influenced service user's self-perceptions; one participant questioned what was wrong with them (Kerman et al., 2019). Some service users also saw themselves as at the bottom of a hierarchy:

> *"it was like a totem pole you know, and clients are at the bottom and the staff they've got the top and they have their laws or this rule or that rule…and they're very, very controlling, these people" (Padgett et al., 2008, p. 230).*

Relationships within services

Service users described the role of interpersonal relationships when discussing their overall experience of mental health services. There appeared to be three key relational aspects to service involvement which shaped service users' perceptions: the approach and qualities of service staff, the experience of the staff-service user relationship, and experiences of other service users.

The approach and qualities of service staff

Service users' perceptions of the service staff and their approach to their work was frequently mentioned when service users discussed their experience of mental health service involvement. Staff members who appeared disrespectful, judgemental, impersonal, unapproachable, and lacking in compassion were perceived negatively, and impacted on the service user's overall experience (Kerman et al., 2019). Experiences of feeling judged and scrutinised deterred engagement with services, and some service users described preferential treatment of homed people compared to homeless individuals, and staff members making assumptions based on stereotypes and prejudicial views, generating perceived stigma (Darbyshire, et al., 2006; Bhui et al., 2006; Pahwa et al., 2018):

> *"…Yeah, [this service] team, I totally do not like them at all, they are so judging. […] I actually had to go through them to be able to see [another service]. […]They are just terrible, they are disgusting." (Darbyshire et al., 2006, p. 557)*

Staff communication abilities were also mentioned in various studies findings, both within staff teams, and between staff and service users. Service users explained how hospital staff who did not consult them or explain what was happening in hospitals made them feel vulnerable, afraid, and sometimes led to anger and erratic behaviour (Darbyshire et al., 2006):

> *"I didn't really like the doctors because they would come in and see you once a week and say, 'No, you're not ready to leave', then walk out' {Darbyshire et al., 2006, p. 556).*

Other service users described experiences with therapists who did not appear to be listening to them, and appeared to be just "going through the motions" resulting in them feeling alienated (Huey et al., 2012, p. 130):

> *"She'll ask me, "how's your Mom?" And I'll tell her about my Mom. Then a couple of questions later she'll say, "so, how's your Mom?" You get what I'm sayin'? […] Are you listening?...It's kinda like what type of counsellor do I got?" (Huey et al., 2012, p. 130).*

A lack of communication between staff members also led to a negative service experience, as high staff turnover and new staff members meant that service users would need to "go through everything all over again" (Darbyshire et al., 2016, p. 558), resulting in frustrations. Some service users also spoke of negative service experiences influenced by poorly trained, non-specialised staff, who displayed "favouritism" amongst service users and lacked skills in conflict resolution (Kerman et al., 2019, p. 780). One paper also found that service users perceived staff to be "playing head games" (Darbyshire et al., 2006, p. 557), which referred to multiple interactions and perceived manipulation and control by authority figures.

Service users also compared privately funded mental health services which they could access through their parents' private health insurance to publicly funded, explaining that public service staff appeared extremely busy, dismissive and "no idea of what it was like" (Darbyshire et al., 2006, p. 557). In contrast, staff within private services were described as having a welcome attitude and more respectful approach:

> *"The only reason why I was allowed to stay there [Hospital X – a private hospital] was because I was under my parent's private cover, they were really good there, really nice […] the people there were very nice" (Darbyshire et al., 2006, p. 557).*

Qualities that service users appreciated in staff were being dependable, responsive, action-oriented, qualified, specialist and fair (Kerman et al., 2019). Multiple papers found that service users appreciated acts of kindness displayed by service staff, which involved staff demonstrating warmth, humanity and making extra effort (Padgett et al., 2008). Service users described these professionals as “good-hearted” and going “above and beyond” (Kerman et al., 2019, p. 70) which was perceived positively and enhanced a trusting therapeutic relationship, and resulted in affirmation that they deserved human caring and support (Padgett et al., 2008; Darbyshire et al., 2006; Kerman et al., 2019):

“It’s like it goes a bit beyond his pay level, that it’s actually a career that he chose because he was passionate about and actually wants to help us” (Kerman et al., 2019, p. 780).

“You think this bad time’s going to go on forever and its never going to end, and when someone, an adult, you know, starts showing interest and care in you and like you feel safe around that person, it’s, that was the start for me.” (Darbyshire et al., 2019, p. 558).

Participants also mentioned the value of having people who listened to them in a non-judgemental and respectful way, which was important for a positive service experience (Taylor et al., 2007, O’Reilly et al., 2009), versus staff who were just “going through the motions” (Darbyshire et al., 2006, p. 558; Huey et al., 2012, p. 130).

“The psychiatrist, it was the fact that she actually listened, I don’t think anybody has actually listened to what I had to say before” (Darbyshire et al., 2006, p. 558)

Experience of the Staff-Service user relationship

The nature and quality of the staff-service user relationship appeared to play an important role in the overall experience and perception of mental health services.

Service users reported strong therapeutic relationships helped to reduce feelings of being alone (Kerman et al., 2019) and facilitated the likelihood of continued engagement and retention within mental health services (Padgett et al., 2008). Positive experiences with service providers were perceived as leading to strong bonds with professionals and the formation of social ties within the mental health service community, which resulted in a sense of "camaraderie" (Pahwa et al., 2018, p. 4):

> *[She] wanted the change. She wanted to see you get better and her support and her being there…she never forgot my birthday" – Tanya (Pahwa et al., 2018, p. 5)*

Confidentiality within the therapeutic relationship seemed to play an important role in the experience of the mental health service and interventions received. Service users reported that a lack of confidentiality and an inconsistent approach to rule application from different professionals resulted in negative perceptions of care (Kerman et al., 2019). For service users who were engaging in mandated counselling to regain custody of their children, they reported that they could not trust their therapist, as the relationship was characterised by the therapist reporting the session content back to a child services case manager, and so deemed therapy as "counterproductive" for personal growth (Huey et al., 2012, p. 129). Female service users who identified as vulnerable reported that they struggled to develop a trusting therapeutic relationship due to previous violent victimisation, and there was a perceived negative cost of trusting strangers with personal details (Huey et al., 2013).

In contrast, service users valued a shared understanding with professionals of confidentiality and the limits around this. Service users explained that this resulted in openness and a sense of safety that their "…'business' would not be repeated or 'gossiped' about" (Taylor et al., 2007, p. 225), which contributed to the perceived effectiveness of a service. Service users also spoke of the value of their mental health coordinator not being a hostel staff member, as this provided a choice of who to speak to, and increased their trust that information would be kept confidential (Taylor et al., 2007):

> *"…She's somebody who doesn't work here, so if I've gotta moan about here, I can actually moan without anyone going 'You can't do that'. It's actually all right having someone who's not here all the time to sit and chat to" – Beth, 19 years old (Taylor et al., 2007, p. 225)*

For some service users, the organisational context and service approach characterised the quality of the therapeutic relationship. Flexible approaches, such as those employed by the Housing First model, resulted in a greater sense of security and therefore the development of stronger relationships between staff and service users, permeated by honesty, openness, non-judgement and support (Watson, 2012):

> *"Because one of the things is that when my case manager asks me did I use, I can tell him 'yeah', and don't feel like I'm being judged [. . .] and not be afraid of what I'm gonna be disciplined with [. . .] and not be worried about, 'Am I gonna be kicked out next week?" (Watson, 2012, p. 340).*

The absence of rigid service participation and abstinence rules appeared to allow staff to form a relationship with service users based on "individuals rather than their illness" (Watson, 2012, p. 340), with service users treated as “a grown individual” (p. 340). Alternatively, inflexible service contexts resulted in staff-service user relationships being organised by service users’ substance abuse diagnoses, resulting in alienation and a negative effect on the therapeutic relationship (Watson, 2012).

Other mental health service users

Perceptions of people who use mental health services, whether resulting from lived experiences or socially constructed stereotypes, influenced service users’ experiences and perceptions of mental health services overall.

Socially constructed ideas about users of mental health service users were sometimes characterised by stigma and stereotypes, and influenced the perception of mental health services. Service users explained how homeless people with mental health difficulties were considered to be of lesser status within the homeless community itself, and there was a sense of compounded stigma and a fear of subsequent treatment by the homelessness circuit, deterring mental health service engagement (Bhui et al., 2006).

Those who used mental health services were perceived as “crazy people” (Bhui et al., 2006, p. 158), and “Nuts, Schiz, Psycho” (O’Reilly et al., 2009, p. 1740). There was a perception that services were to be used by those who were experiencing acute and serious mental illnesses resulting in them being locked away, rather than services being appropriate for a broader range of distress (Bhui et al., 2006). This was a barrier to homeless individuals admitting they had a mental health difficulty to themselves and others, resulting in service avoidance. One service user spoke of the perception of the type of people that saw the mental health coordinator (Lilly Smith):

Well I got told the other week off a certain resident that if yer go and see Lilly Smith you're loopy in the head [. . .] an' I thought to meself no you're not loopy in the head, you jus' need somebody t'talk to…] – Karen (O'Reilly et al., 2009, p. 1741).

Service users explained how other services users played a role in their experience of a service as safe and secure. Female service users reported feeling safest in women only groups, and conflicts (i.e., bullying, theft, physical altercations) amongst others using the service resulted in individuals feeling unsafe (Kerman et al., 2019). The visible intoxication / use of substances by other service users was triggering for individuals in recovery and resulted in service users feeling unsafe.

The mental health service community was reported to be a source of socialisation, relationships and friendships, resulting in the development of social ties and reducing the sense of social isolation for service users (Pahwa et al., 2018). Service users who felt they could relate to others involved in the service due to similarities in backgrounds and experiences described a sense of solidarity, connection, belonging and friendship, contributing to a positive service experience (Kerman et al., 2019).

"They were all having the same issues that I have in life. I wasn't no different than anybody else" (Kerman et al., 2019, p. 780).

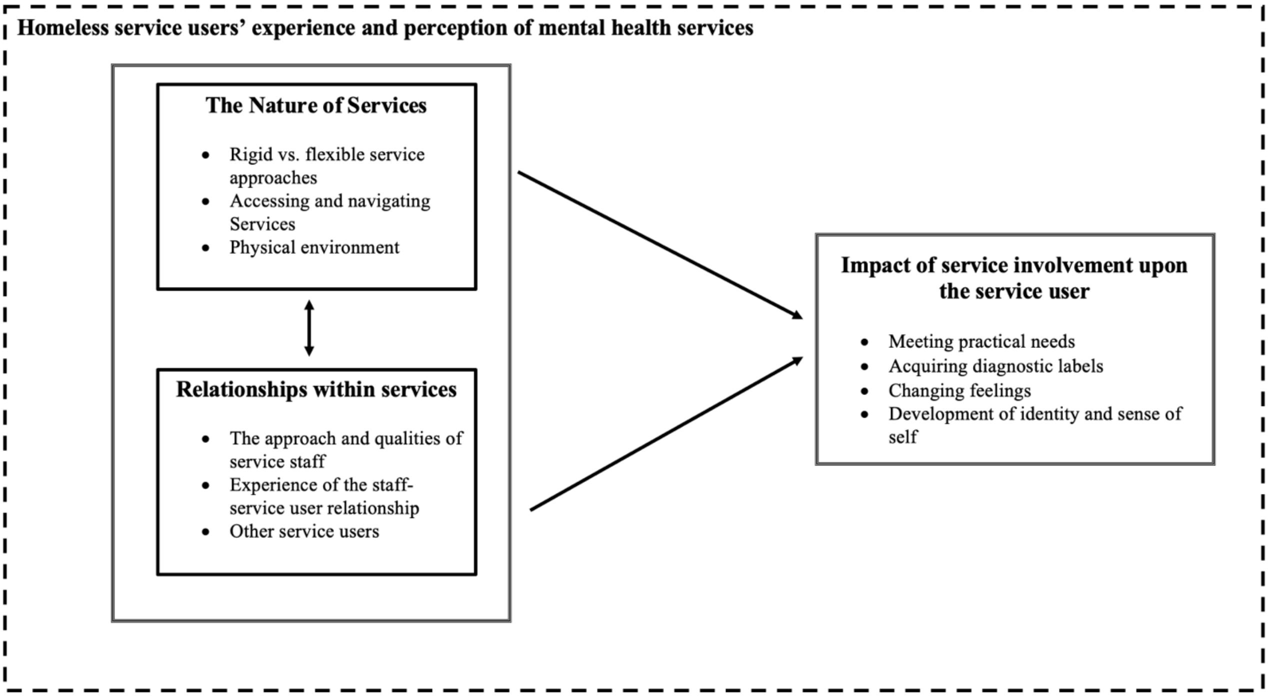
However, when others using the service were perceived as dissimilar due to differences in hygiene, mental health issues or substance use, they were labelled as 'crazies' and 'junkies', resulting in distancing from these mental health service users and a negative experience of the service:

> *"You're just surrounded by junkies who scream and yell and throw things all night … the people there are just out of control" (Kerman et al., 2019, p. 780)*

Discussion

The present review aimed to explore the influences on homeless service users' experience and perception of mental health services. Such influences appeared to fall into three overarching factors: the nature of services, the impact of service involvement and relationships within services. There appeared to be emerging relationships and interactions between the factors, which are proposed in Figure 2.

Figure 2. Emerging relationships between factors.



The nature of services

The nature of mental health services appeared to play a key role in shaping the impact of service involvement upon the service user (see Figure 2), which influenced the overall experience and perception of mental health services. Services that utilised rigid rules and policies were experienced as limiting service users' control and agency over their own lives, creating feelings of powerlessness, helplessness, abandonment and forced emotional vulnerability. Such policies became a barrier to access and engagement, particularly for those who were dependent upon substances, which aligns with the eligibility barriers identified in other 'hard to reach' groups (Lamb et al., 2012).

In contrast, flexible choice-oriented services allowed individuals to have agency, take ownership of their achievements and juggle multiple demands in their lives, which resulted in feelings of pride, relief, safety, security and increased self-esteem. This finding aligns with the general service user experience literature, which highlights the importance of taking control, having choices and establishing safety and security (Faulkner, 2000). The present review findings also highlighted the importance of good quality physical environments for service users to feel calm and safe, which fostered their sense of self-worth.

Research has previously identified agency as a vital construct within mental health recovery, which involves recapturing "authorship and ownership of one's thoughts, feeling and actions" (Lysaker, & Leonhardt, 2012, p. 165). Agency has been suggested to spark a turning point in individuals' recovery narratives whereby they develop purpose and meaning in their lives (Lapsley, Nikora & Black, 2002; Wyder, Bland & Crompton, 2016; Adler, 2012). As such, it is suggested that mental health services and interventions should "stimulate personal initiative, rather than creating dependency" (Lapsley et al., 2002, p. 72). Therefore, the way services position themselves and their role may relate to how able service users are to develop agency within their life narratives.

Relationships within services

Relationships within services played a key role in shaping service users' experiences of mental health services, with close links to the 'Changing feelings' subtheme (See Figure 2) – negative interactions with staff left service users feeling vulnerable, afraid, angry and alienated. The wider service approach organised the interactions and relationships between staff and service users (see Figure 2). For example, services enforcing strict substance abstinence requirements resulted in therapeutic relationships organised by substance use diagnoses, control, mistrust, and secrecy.

Perceptions of staff as being compassionate and non-judgemental enhanced relationships and had positive implications for service users' sense of self; that they were a person deserving of human caring and support. As such, treatment by others related to how service users believed that they should be treated, which played a key role in individual narratives of recovery and growth. This finding aligns with the broader service user experience literature, which highlighted the importance of perceived acceptance, positive interpersonal relationships with service providers and the continuity of care (Newman et al., 2015; Faulkner et al., 2000). Positive experiences with other service users also resulted in the development of social ties, which positively influenced service users' feelings and likelihood of continued service engagement.

The Network Theory of Social Capital (Lin, 2008) may provide one understanding for the mechanism by which relationships within services become instrumental to service users' experiences and recovery journey. The forming of social ties – as discussed in one reviewed paper (Pahwa et al., 2018) - within mental health services may help to enhance and mobilise service users' social capital (i.e., resources embedded in one's social networks) (Lin, 2008). This may be particularly beneficial to recovery for service users affected by homelessness, who may have a smaller number of transient social ties. Relationships within services may help individuals to bridge their social capital and access additional community resources (Pahwa et al., 2018).

The wider systemic context must be considered when trying to understand negative experiences of mental health service staff. Staff burnout and compassion fatigue has been commonly identified in mental health services (Rossi et al., 2012), which may result in emotional exhaustion, depersonalisation/cynicism and reduced personal accomplishment (Maslach, 1993). Burnout has been associated with: impaired job performance; a lessened ability to be empathic, collaborative and attentive; and increased negative attitudes and feelings towards service users, which have been found to lessen service user satisfaction (Morse, Salyers, Rollins, Monroe-DeVita & Pfahler, 2012). As such, negative perceptions and experiences of staff members may be related to the presence of burnout and compassion fatigue within services. Different organisational context factors within public and private services may also influence the amount of staff burnout; this could be a systemic factor explaining the varying experiences of service users across different settings. A systems approach to professional well-being proposed by the National Academies of Sciences, Engineering, and Medicine (2019) highlighted systemic factors contributing to clinician burnout, such as excessive workload, inadequate staffing, time pressures, the organisational culture and job flexibility and autonomy. These work-system level factors may sit within the wider systemic context, including at a Macrosystem and Chronosystem level (Bronfenbrenner, 1977), whereby services have experiences cuts in government spending as a result of austerity policies, resulting in a staffing crisis and depletion of resources (Trade Union Congress, 2018). The explicit impact of these factors on homeless service users' experience and relationship to services may be a future research need.

Impact of service involvement upon the service user

Services that supported service users to meet their practical needs by helping them to navigate the system, secure housing and attend essential appointments resulted in a positive experience of services. For some, service involvement was felt to be a constraint rather than a resource to get basic survival needs met. This was due to competing priorities and limited time and energy resources, which aligns with the barriers identified by Lamb et al. (2012) for 'hard to reach' groups generally. When individuals were considering accessing services, beliefs about other mental health service users also influenced the perceived implications for their own identities as a person who used services.

The acquiring of labels, whether diagnostic or behavioural, was discussed as constraining understandings, compounding the stigma and marginalisation service users already experienced, and perceived as threatening to their identities. This is comparable to a previous review in which members of 'hard to reach' communities rejected imposed diagnostic understandings, which resulted in a disparity in sense-making between professionals' and service users, constraining relationships (Lamb et al., 2012). The previous review also indicated that service users from ‘hard to reach’ groups believed that their difficulties originated from social adversity as opposed to a mental illness. Similarly, the quote featured within the present review also illustrates the rejection of imposed identities - *“I ‘ad problems I didn’t ‘ave mental health problems”* (O’Reilly et al., 2009, p. 1740).

It is surprising that the reviewed papers did not identify an alternative perspective on the acquisition of labels, for example their potential benefit to help access specific services. It is wondered whether this absence may reflect author bias or information selectivity within the reviewed papers, although this is difficult to ascertain due to the lack of information on the researchers’ own positions.

Additional theoretical implications

Overall, the findings of the literature review seem to align with Maslow’s Hierarchy of Needs (Maslow, 1943). Appendix H demonstrates each level of need and suggests how the literature review findings and subfactors may be associated with each. This theoretical construct suggests that a person’s physiological needs must be met first, prior to their higher order needs becoming possible to achieve. The separate concept of ontological security may also be relevant here, which may be considered within the Safety Needs portion of Maslow’s Hierarchy of Needs. First coined by Laing (1965), ontological security refers to the feeling of wellbeing gained from “a sense of constancy in one’s social and material environment” (Padgett, 2007, p. 2). Housing permanence is suggested to be essential for the development and maintenance of ontological security, which then can provide a foundation for the development of a strong self-identity and self-actualisation (Padgett, 2007). Padgett (2007) found that Housing First programs enabled service users to establish elements of ontological security: they felt in control of their lives, they established routines of daily living, used their freedom to make their own choices, gained privacy, and were able to repair and construct new identities. As such, it appears that personal agency, control and choice may also play a role in the development of ontological security.

Critical Appraisal

PRISMA guidelines (Moher et al., 2009) were followed to enhance methodological quality and transparency, and to allow the assessment of trustworthiness by the reader. Quality assessment procedures deemed all papers to be of satisfactory quality, with most checklist criteria being fulfilled, strengthening the findings of the review. An additional researcher completed quality assessment of three papers which increased inter-rater reliability.

Researcher reflexivity and the explicit acknowledgement of the researcher's role in co-creating meaning with participants is an important component of high-quality qualitative research (Finlay, 2002). Thus, the absence of the reflexive position of the researcher across papers made sources of bias difficult to consider.

One paper appeared to draw particularly strong yet unconvincing conclusions, that did not seem to be firmly rooted in the data (Huey et al., 2012). The paper presented one example of a participant who described themselves as satisfied with the outcome of their therapeutic counselling sessions. The researchers appeared to impose their own assumptions on the experience of the service user, and concluded that because the participant did not mention Cognitive Behavioural Therapy or relaxation therapies, it appeared to be "inappropriate treatment for their particular issue" (p. 130). A lack of detailed exploration of the stories of the 30/44 service users that were satisfied with their counselling may have been steered by researcher bias. It is stated in the conclusions that "homeless women are frequently not provided with quality mental health services" (p. 131), which appears to be a far-reaching conclusion based on the qualitative data presented. A lack of researcher reflexivity across papers may have potentially affected the strength of the review.

The obtained papers varied in terms of their reporting of the cultural and ethnic diversity of their samples. It must be noted that Australia, the USA and Canada have significant colonisation histories, resulting in the significant marginalisation of indigenous people by those in power. Indigenous people are disproportionally represented within homeless population demographics – 20% in Australia (compared to representing 3.3% of the Australian general population; Australian Institute of Health and Welfare, 2020), 5% in the USA (compared to representing <1% of the USA general population; Henry, De Sousa, Roddey, Gayen & Bednar, 2021), and 30% in Canada (compared to representing 5% of the general population; Hunter, 2018). It appears that indigenous people were also under-represented within the samples of the papers that did report the ethnic demographics of their samples. As such, this review may not be representative of the experiences and perceptions of indigenous people in relation to the research topic, and this may be an area for future research.

Implications

This review has demonstrated the multiple influences that shape homeless service users' experiences and perceptions of mental health services. This may contribute to understanding why many homeless individuals with mental health needs do not, or cannot, access mental health services. Subsequently, this provides considerations for service development professionals and clinicians when considering how to best meet the needs of this population.

Services should support individuals to meet their basic physiological needs prior to embarking on additional psychological interventions. Service users suggested this could be done by offering integrated housing and mental health support, or by services supporting them to access and navigate the system by filling out forms and accompanying them to appointments. Services that are ‘in house’ (accessible within hostel/accommodation environments) have multiple benefits, one of which is reducing the logistical difficulties of transport, time, and money needed to attend appointments. This also improves visibility of mental health support and increases ease of access. It may be important for community mental health services to have a street outreach team, to increase awareness and help mitigate access barriers.

Homeless service users have multiple complex psychosocial stressors to navigate daily, and mental health services should be willing to adapt their policies and procedures to account for this. Accessibility of housing and mental health support should not be rigid and conditional. Instead, services should be flexible, non-judgemental, and supportive, to enable service users to develop a sense of safety and ontological security vital to their recovery and identity. Mental health services with flexible hours, appointment locations, eligibility criteria and frequency/method of communication are needed. Service developers should not overlook the importance of the service’s physical environment; quiet, clean, calm, and private environments have benefits for service users’ psychological wellbeing and self-worth.

Service models should promote choice, personal agency and empowerment, as opposed to authority, hierarchies, control and restriction. Interventions should consider individual needs and contexts and be person-centred and needs led – therefore, mandated interventions should not be imposed upon service users. When recruiting staff, the match between their professional values and the service's philosophy should be assessed, to ensure staff are best placed to develop positive alliances with homeless service users and enact flexible and choice-driven service approaches.

Implications for clinicians include the importance of detailed communication within the service, but also with external agencies, to prevent service users having to continually repeat their stories. The review identified that transparent communication, the encouragement of dialogue and optional exploration is vital to ensure care is truly person centred and choice driven. The review emphasised the importance of staff being skilled, well trained (particularly in listening and conflict resolution) and conveying warmth, humanity, and kindness. Although the relationship between staff wellbeing and service user experiences and perceptions is beyond the scope of this review, future research may aim to explore this relationship.

Services should consider explicitly positioning themselves as providing support for multiple forms of distress resulting from a variety of circumstances, rather than as a mental illness treatment service. This may increase the likelihood of homeless individuals accessing support, enhancing opportunities for the co-construction of meaning and fostering the development of meaningful therapeutic relationships.

Nevertheless, this review highlighted the importance of interactions and relationships between staff and service users, which shaped homeless service users' experiences, perceptions, and identities. Reducing burnout and compassion fatigue by minimising organisational pressures and ensuring manageable workloads, may contribute to the optimum conditions needed for positive therapeutic alliances to form.

Conclusions

There are multiple complex influences that shape the perceptions of homeless service users in relation to mental health services. This review highlights some of these influences: the nature of services themselves, the impact of service involvement upon the service user and relationships within services. Services that were flexible, easily accessible, choice-driven, and non-judgemental were experienced positively by service users. They promoted personal agency and facilitated the journey towards recovery and self-actualisation. Services that enact these values may encourage the development of ontological security and positive relationships for service users, facilitating their development at different levels of need. This review emphasises the importance of attending to service users' voices within research and clinical contexts and demonstrates important considerations for service development. Future qualitative research should consider encompassing researcher reflexivity to allow the voices of the service users to be disentangled from the position of the researcher.

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Part Two: Empirical Paper

This paper is written in the format ready for submission to the journal

The International Journal of Qualitative Studies on Health and Wellbeing

Please see Appendix I for the submission guidelines

Word Count: 12,503

(excluding references)

Distressing unusual experiences and beliefs in the lives of previously homeless individuals: A Narrative Analysis of the stories of White British Men

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Abstract

Purpose

Research suggests a correlation between homelessness and the prevalence of distressing unusual beliefs and experiences - previously understood as 'psychosis' or 'schizophrenia'. Existing literature has utilised the medical model to present prevalence findings, with minimal exploration of psychological influences and understandings. The study aimed to explore how previously homeless individuals make sense of distressing unusual experiences and beliefs, by hearing their stories.

Method

Narrative Analysis was used to understand the stories of six previously homeless White British males who reported distressing unusual experiences and beliefs.

Results

Participants' stories involved a holistic and whole-life approach when making sense of distressing unusual beliefs and experiences. Plots moved between similar phases and included interpersonal experiences (trauma and abuse; loss; judgemental attitudes; fitting in and relational coping), and their intrapersonal consequences (physical and psychological wellbeing; substance use; spiritual, religious and paranormal experiences; and safety, security and stability). Multiple identity positions were adopted during the construction and communication of meaning.

Conclusions

A holistic, psychosocial and whole-life approach may be helpful to support homeless individuals to make sense of DUBE and their coping responses. It may also be helpful to consider the changing sense of power, agency and autonomy when hearing their stories.

Key Words: hearing voices, homeless, trauma, substance use, distress, unusual experiences, unusual beliefs, psychosis

Introduction

It is estimated that 320,000 people are considered 'homeless' (Reynolds, 2018), which can be defined as rooflessness (a person without shelter of any kind, also known as 'sleeping rough'), living in insecure housing such as temporary accommodation or 'sofa surfing' (Public Health England, 2015). A national audit suggests that 80% of homeless individuals in England are experiencing psychological distress (Homeless Link, 2014).

Despite this population's high need for support, one report found that only 26% of homeless professionals believed rough sleepers in their area could access such support (Glew & Orchard, 2016). Homeless communities have been found to attend Accident and Emergency departments at an increased rate, of around 60 times that of homed individuals, which may be in part due to the inaccessibility of primary care (Reilly, Hassanally, Budd & Mercer, 2020; Glew & Orchard, 2016). The NHS Mental Health Implementation Plan stated that by 2023/24, 20 high-need areas in the UK will have established specialist trauma-informed mental health services for homeless individuals (NHS England, 2019). Given this, it is essential to further understand how professionals can best support homeless individuals experiencing psychological distress.

In particular, research suggests that homeless communities report distressing unusual experiences and beliefs (DUBE) more frequently than homed populations (Folsom & Jeste, 2002 ; Perälä, et al., 2007). Research has found that 47% of individuals 'sleeping rough' in the UK reported that they had experienced 'psychosis' (Gill, Meltzer & Hinds, 2003) and 18.2% reported specifically hearing voices (Homeless Link, 2014). This research defines DUBE as seeing, hearing, tasting, smelling or feeling experiences which others do not commonly experience (e.g., hearing voices). The research defines 'unusual beliefs' as holding beliefs that other people do not share, and can be considered 'unusual' given the person's socio-cultural context.

People who seek help for DUBE may be diagnosed with a mental illness, which has been termed 'psychosis' within western society (American Psychiatric Association, 2013). The label 'psychosis' may be associated with the dominant construct that DUBE are best explained as an 'illness', which can result in stigma (Franz, et al., 2010). This explanation may not represent some people's understanding of their experiences. It may be more useful to take an 'individual complaints' stance suggested by Bentall (2006), to understand the psychological influences involved in the development and maintenance of *specific* unusual experiences (e.g. hearing voices). However, it must be noted that much of the existing literature uses terms such as 'psychosis' or 'schizophrenia' without discerning *what* a person's unusual experiences consist of.

Research suggests that two thirds of homeless individuals reported that their DUBE began prior to becoming homeless, with one third reporting that these began after homelessness (Odell & Commander, 2000). Commander and Odell (2001) found that homeless individuals diagnosed with 'Psychosis' report more severe and distressing unusual experiences compared to homed individuals. Homeless individuals may also experience increased difficulties with visual learning and social cognition alongside DUBE, compared to those who are homed, which has been associated with more days spent in unsheltered locations (Llerena, Gabrielian & Green, 2018).

The majority of the existing literature surrounding homelessness and DUBE utilises a medical model of understanding, which may be considered reductionist. It fails to consider

DUBE as anything other than an illness which needs treating, without exploring the potential for person-centred explanations of unusual experiences and beliefs. An alternative understanding is gaining traction, which demonstrates how DUBE could be considered as understandable reactions to adverse life events and circumstances (Read, Mosher & Bentall, 2004).

A report published by The British Psychological Society criticised the illness model of DUBE, and communicated how trauma, relationship difficulties, inequality, poverty, racism and discrimination may have psychological impacts that result in DUBE (Cooke, 2017). One literature review presented the evidence for the causal role of adverse experiences in developing ‘psychosis’ (Read, Bentall & Fosse, 2009). Such adverse experiences included: being the product of an unwanted pregnancy; loss of parents through death or abandonment, parental separation, witnessing domestic violence; childhood sexual, physical and emotional abuse; neglect; war trauma and bullying (Read et al., 2009). Research has also identified that living in dense, urban environments with a high level of economic deprivation and inequality increases the likelihood of developing DUBE (Kirkbride, Jones, Ullrich & Coid, 2012).

Various theories for the causal relationship between trauma and the development of DUBE have been proposed. Humans continually understand the world around them in the context of past experiences. As such, distressing life experiences affect the way in which the world, others and the self are perceived, understood and responded to (Cooke, 2017). One model (Hardy, 2017) attempts to conceptualise this link, by suggesting that trauma can lead to the development of three vulnerability factors: 1. Ways of surviving the trauma become ingrained emotional regulation strategies (cognitive, affective, interpersonal and behavioural responses), 2. Event memories are affected by emotions experienced during trauma, 3. These event memories shape appraisals of the self and others (personal semantic memory). The model proposes that these three factors may lead to two types of intrusions: 1. Unusual experiences occur as a result of emotional regulation, or as a result of novel images created from the trauma memory, 2. Intrusions of the trauma memory reflecting a person's perceptual, episodic and personal semantic representations of the trauma. A person's appraisal of these intrusions is affected by their appraisals of themselves and others, and their coping mechanisms to these intrusions may be influenced by their usual emotional regulation strategies.

Homeless individuals have been found to have an increased likelihood of traumatic experiences, both before and during homelessness. Research suggests that 78% of 102 homeless individuals had experienced bullying, 63% had been socially isolated, 61% had been assaulted and 61% feared being killed or injured (Coates & McKenzie-Mohr, 2010). Homeless individuals experienced more physical assault and felt more frightened of muggings and being killed since becoming homeless. Homeless individuals scored considerably higher on all items of The Trauma Symptom Inventory (Briere, 1995) than both homed individuals, and homed individuals who were mistreated as a child, suggesting the experience of being homeless itself may compound existing childhood trauma.

The 'Social Defeat Hypothesis' also proposes an understanding of the causal link between adverse experiences and DUBE (Selten & Cantor-Graae, 2005). This suggests that long-term 'social defeat' and exclusion from the majority group may cause a person to experience increased psychosocial stress, sensitising the mesolimbic dopamine system (Selten & Cantor-Graae, 2005). This sensitisation has been linked to the development of unusual experiences and beliefs and an increased reliance on dopamine-enhancing substances (e.g. cannabis, heroin) (Selten & Cantor-Graae, 2005). Homeless individuals may be considered as experiencing ‘social defeat’, as all levels of human need are often affected by homelessness (See Figure 1; Maslow, 1943). Boydell, Goerin and Morrell-Bellai (2000) found that homelessness may be experienced as a loss of identity, by causing people to feel devalued, ‘disgusted’ with themselves and as if they have ‘lost their pride’. Homeless individuals also spoke about feeling socially isolated and trapped in the homeless ‘way of life’.

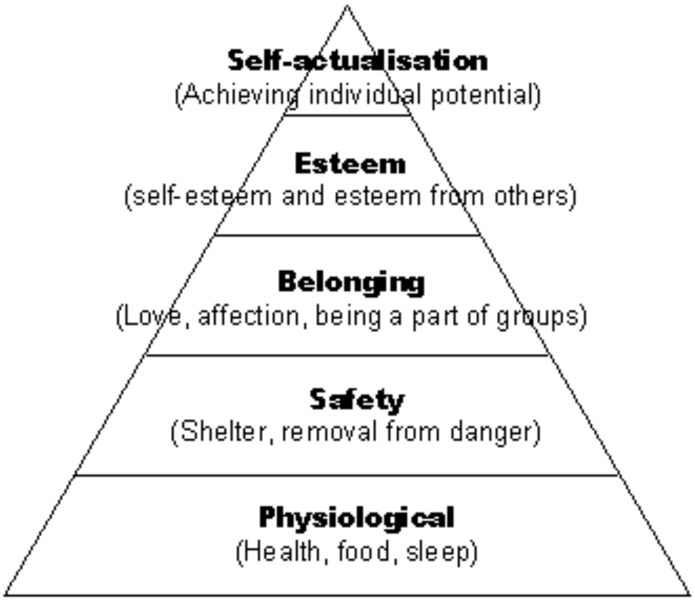


Figure 1. Maslow’s Hierarchy of Needs (Maslow, 1943).

The label ‘homeless’ has been found to be associated with severe stigmatisation and found to elicit negative reactions in others (Phelan, Link, Moore & Stueve, 1997). Homeless individuals have experienced discrimination from health care providers, in the form of ‘unwelcomeness’, which led to feelings of dehumanisation and disempowerment (Wen, Hudak & Hwang, 2007). Research suggests a causal link between discrimination and the subsequent development of DUBE (Janssen, et al., 2003). Luhrmann (2007) has also suggested that social defeat acts as a perpetuating factor for DUBE, by causing demoralisation, internalised stigma, and helplessness, which adversely impact the well-being 'recovery time.'

For some individuals, developing DUBE may impact financial and housing stability. Odell and Commander (2000) suggested that isolation from childhood carers and substance misuse may predict whether a person with DUBE becomes homeless. DUBE can lead to employer prejudice and difficulties gaining and maintaining a job (Hampson, Hicks & Watt, 2017). Alongside unemployment difficulties, hospital admissions due to DUBE may make it difficult for home tenancies to be maintained, potentially resulting in homelessness (Tulloch, Khondoker, Fearon & David, 2012).

Aims and rationale

Homeless individuals are more likely to have experienced trauma, adversity, discrimination, social exclusion and unmet human needs, all of which may lead to high psychosocial stress and perceived 'social defeat' within society. It seems that there may be a potentially circular relationship connecting trauma, DUBE and homelessness. Traumatic and adverse experiences may lead to DUBE, which in turn can lead to homelessness, which may also be experienced as traumatic and lead to a reliance on substances, both of which may further maintain DUBE.

The existing literature largely medicalises DUBE within homeless communities, and mostly focuses on prevalence and statistics. Although there is undoubtably an increased frequency of DUBE in homeless communities, there is a paucity of literature understanding the relationship between homelessness and DUBE. There seems to be a gap in the literature for qualitative research that values and prioritises the individual meaning of a person's experience. Thus, the ‘voice’ of individuals who have experienced homelessness and DUBE is lacking, providing a gap for rich, qualitative research.

It is hoped that the current study may contribute to a richer understanding of the relationship between homelessness and DUBE from the perspectives of the participants. Qualitative exploration may foster an understanding of how these individuals make sense of DUBE in the context of homelessness experiences, and how they convey such sense-making. Hearing a different construct of DUBE may lead to validation and empowerment of individuals and professionals to see DUBE from an alternative perspective, rather than the dominant construct of their experiences as an ‘illness’. It is also hoped that amplifying the voices of marginalised individuals may foster further compassion and understanding in healthcare settings, and may reduce the ‘unwelcomeness’ some homeless individuals experience (Wen, Hudak & Hwang, 2007). The findings may also generate further research interest in understanding the psychological experience of homeless individuals, which could help to inform the future adaptation of services to improve accessibility and quality. The research questions are:

1. *How do previously homeless individuals make sense of their distressing unusual experiences and beliefs?*

2. *And how do they convey this sense making through the stories in which they tell?*

Method

Design

A qualitative narrative methodology was used, in line with the research questions, which consider how meaning is assigned to lived experience and conveyed through the stories in which people tell (Willig, 2013). It has also been suggested by The Centre for Narrative Research (2008) that narratives themselves can be important for social change, fitting with the overarching research aims.

Specifically, the research design was informed by the Narrative Oriented Inquiry framework (NOI; Hiles and Cermak, 2008). This specific framework was chosen due to its synthesis of the existing narrative analysis literature and perspectives, clear steps to analysis (See Figure 2) and its inherent separation of the 'telling' of the story from the 'told', which was felt to align with the research questions. In line with NOI, a narrative interview elicited participants' stories, which followed four phases: 1.) Introduction and explanation to the research 2.) The narrative 3.) Questioning phase and 4.) Conclusion (Anderson & Kirkpatrick, 2016). A statement of research interest was read to each participant, followed by an open invitation for participants to tell their stories (See Appendix J).

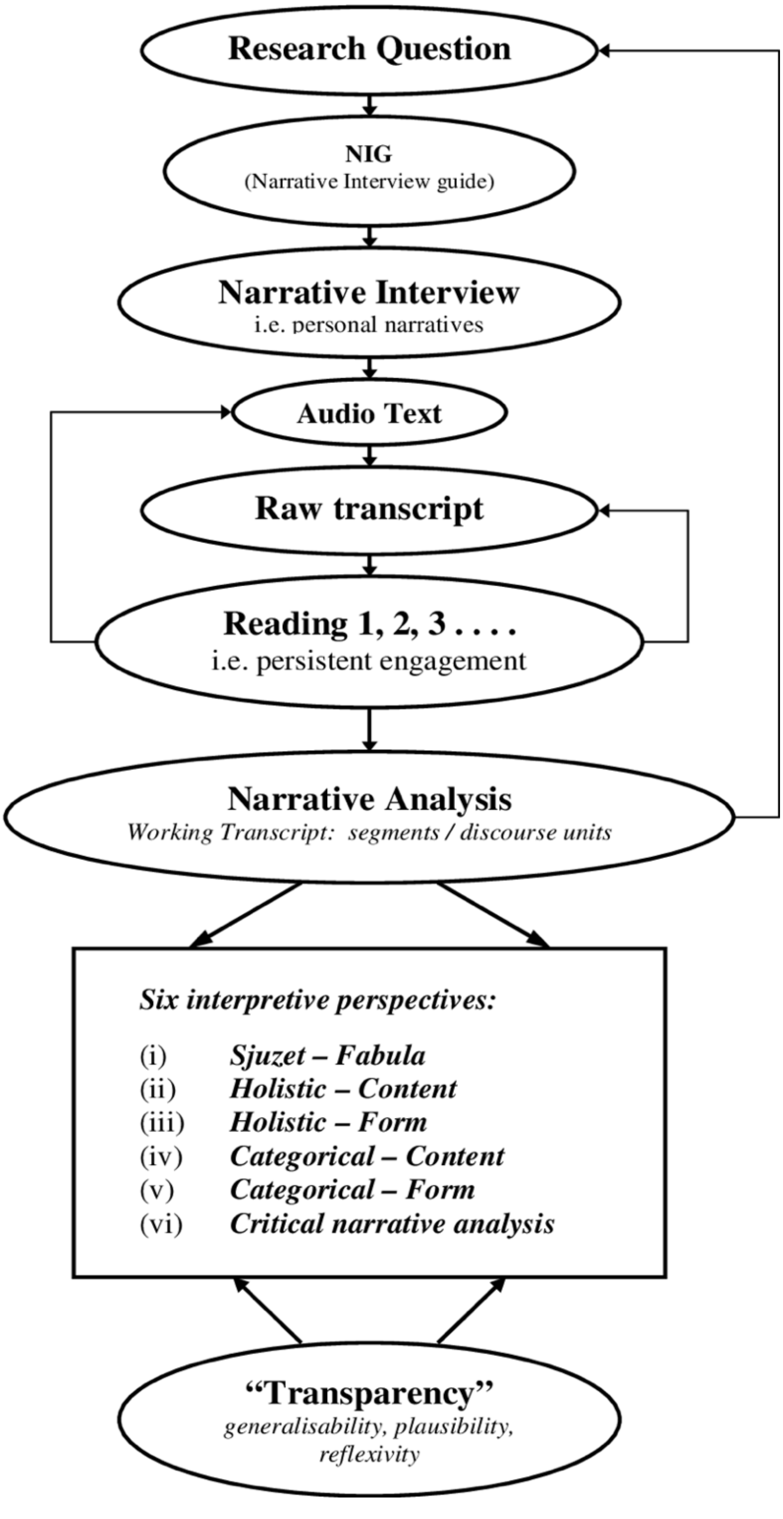


Figure 2. Diagrammatic representation of NOI. (Hiles and Cermak, 2008)

During ‘The narrative’ phase, the participant told their story without interruption from the researcher. Following a clear sign that the participant had finished their story, the questioning phase asked the participant if they could elaborate on different aspects of the story.

Participants and Recruitment

Ethical approval was obtained from the University of Hull, Faculty of Health Sciences, Research Ethics Committee (See Appendix K). Six participants took part in the study, which were recruited via self-selecting purposive sampling. There is no recommended sample size for narrative analysis. Therefore, the general guidelines for qualitative studies were used – recruitment was terminated when no new information was felt to be arising from the data (Patton, 2015). Participant pseudonyms and demographic information can be found in Table 1.

Table 1. *Participant characteristics.*

Pseudonym	**Gender**	**Age**	**Ethnicity**	**Overall length of time spent homeless**	**Length of time as a companion in charity accommodation**
Martin	Male	38	White British	18 months	4.5 years
Robert	Male	55	White British	Approximately 16 years (sporadically)	First time: 2 years Second time: 3.5 months
Steve	Male	30	White British	9 years - Sofa surfing. 1 night rough sleeping.	9 months
Harvey	Male	39	White British	8-10 years sporadically	First time: 6 months Second time: 5 months
James	Male	39	White British	Sofa surfing homeless – 6 months total (across 6 years)	5 weeks

				Rough sleeping: 3 nights	
Andrew	Male	43	White British	25 years – sporadic sofa surfing/rough sleeping	3 months

Participants were recruited from a charity providing residential accommodation and meaningful work for previously homeless individuals in a northern city in Yorkshire, England. The participant inclusion and exclusion criteria were as follows:

(i.) Inclusion Criteria

- Currently a ‘companion’ within the charity organisation
- Self-identification of having experienced homelessness at one point in their lives, for any length of time (inclusive of rough sleeping, temporary accommodation and sofa surfing)
- Self-report of having had distressing unusual experiences (defined as seeing, hearing, tasting, smelling or feeling experiences which others do not commonly experience) and/or beliefs (holding beliefs that other people do not share, and may be considered ‘unusual’ given the person’s socio-cultural context).
- The identified unusual experiences and/or beliefs could have occurred at any point in the person’s life, and may still be occurring.
- Participant’s may have received diagnoses due to their experiences (i.e. ‘schizophrenia’ or ‘psychosis’), but a psychiatric diagnosis is not required for participation
- English-speaking.
- Over 18 years of age
- Able to give informed consent to participate

(ii.) Exclusion Criteria

- Non-English speaking individuals
- Individuals unable to give informed consent

Procedure

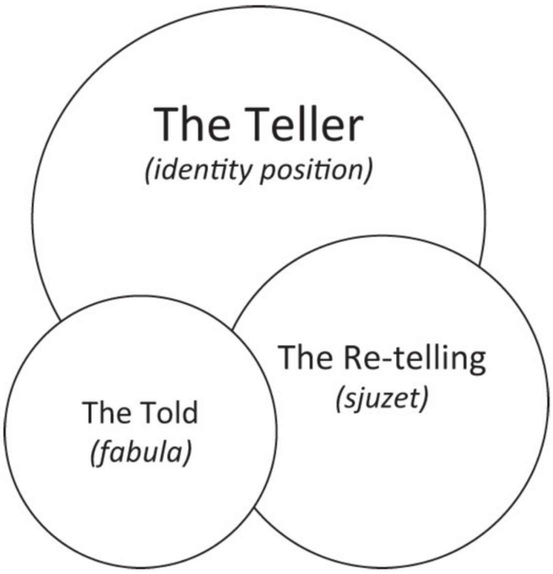
Support workers at the charity organisation circulated an advertisement poster (Appendix L) and information sheets (Appendix M) to companions, and discussed the research during companion meetings. Participants that were interested completed the ‘Consent to be contacted’ form (See Appendix N), which was passed on to the researcher by the support workers. The researcher contacted the potential participants by telephone to assess eligibility to take part, and provide an opportunity for questions. The opportunity for consideration time was provided to participants prior to giving informed consent. After the consent to participate form (Appendix O) was completed by participants, a time and date for the interview was arranged. Interviews took place through Microsoft Teams video calling software, due to COVID-19 restrictions on face to face research activity. The support workers provided companions with access to a laptop. The interview was recorded on an NHS encrypted laptop. Following the research interview, participants were thanked for their time, offered a copy of the transcript upon completion, provided with a £10 Amazon voucher as reimbursement for their time, and sent a sources of support information sheet (Appendix P).

Interviews took place over three months (November 2020 – February 2021). Interview duration ranged from 51 – 127 minutes (mean = 75). Interview recordings were transcribed verbatim, with identifiable information removed to protect participants’ anonymity. Participants were given a pseudonym.

Data Analysis

Data analysis followed the steps of NOI (See Figure 2; Hiles and Cermak, 2008). The raw transcript was repeatedly read and organised into numbered segments to produce a working transcript. From the interpretative perspectives offered by NOI, four were selected and applied to each transcript, to ensure a thorough and comprehensive analysis of both the content and the form of the stories, as well as analysing the way in which they were told. An example of transcript analysis can be found in Appendix Q. Three full transcripts were shared and discussed with two research supervisors, to increase the likelihood of a rigorous analytic procedure, and to contribute to the process of transparency and reflexivity denoted by the NOI model.

1.) **Sjuzet – Fabula perspective** – NOI deems this an essential initial coding component of transcripts (See Figure 2) (Hiles and Cermak, 2008). The 'fabula' refers to the outline of the key events of the story, comprising of the basic storyline (See Figure 3). The Sjuzet refers to the way in which the story is told within its particular context, which adds colour and personal meaning. This interpretative perspective involved separating these components within transcripts, by underlining the Sjuzet, and leaving the Fabula non-underlined. Text considered to fall within both Fabula and Sjuzet were underlined and bracketed.



Source: Adapted from Hiles et al., 2009

Figure 3. Diagrammatic representation of the different components of a narrative (Hiles, Čermák & Chrz, 2009).

2.) Holistic – Content Perspective (Lieblich, Tuval-Mashiach, & Zilber, 1998).

This perspective explores and establishes the links and associations within the entire story, with emphasis on the fabula (Hiles & Čermák, 2008). This perspective is particularly pertinent to Research Question 1, as it provides a holistic picture of participants' sense making across their stories, and highlights the factors that they consider to be important in this process. The Holistic-Content analysis involved:

(i) Reading the transcript several times until story foci emerged

(ii) Putting the first holistic impression of the story into writing, noting key elements and unusual features of the story

(iii) Deciding on special foci/themes that repeatedly appeared throughout the story in a meaningful way

(iv) Marking the various themes in the story by electronically highlighting the transcript

(v) Tracking the results of following the themes/foci and noting any conclusions

In relation to the sense making component of Research Question 1, the resulting key foci and themes were interpreted as the important factors, experiences and concepts that participants consider when making sense of DUBE in the context of homelessness.

3.) **Holistic – Form** (Lieblich et al., 1998). This perspective related to Research Question 2, which is concerned with ‘how’ participants convey their sense making processes through the stories in which they tell. Holistic-Form analysis focuses on both the fabula and sjuzet of the story. It explores the story’s plot and structure, to uncover the ‘form’ and reveal the punctuations and turning points, whilst exploring how the overall expression of the story changes in relation to the sequence of events (Lieblich et al, 1998). Narratives may be progressive, regressive or stable in their development, with often complex life stories encompassing all three types of narrative progressions (Gergen & Gergen 1998). A plot analysis and graph of the individual narratives were produced with consideration to the stages provided by Gergen & Gergen (1998):

(i) Understanding how the story develops, with consideration to how it begins, and where it ends
(ii) Selecting events and significant characters that contribute to the story’s end point
(iii) Re-writing the events in a chronological order
(iv) Developing causal links
(v) Considering demarcation signs

The six individual plot graphs were then compared to assess commonalities and differences, with similar graphs combined to create an overall plot graph.

4.) **Critical narrative analysis/Identity Positioning perspective** (Hiles, 2007 ; Emerson & Frosh, 2004).

It has been proposed by Hiles (2007) that “we participate in the construction of our own identities, and it seems that we can do this in a major way through narrative, i.e. through the stories we construct of the person we are” (p. 34). As such, in order to understand ‘how’ individuals convey sense making of DUBE through their stories (Research Question 2), it is necessary to look at the identity positions that they adopt. This perspective focused on the sjuzet to identify and code the multiple inter-related identity positionings the participant used to convey meaning. The identity positions across stories were then considered together to explore commonalities.

Researcher position

The primary researcher was a White-British, 24 year old female Trainee Clinical Psychologist. The researcher had no previous personal experience with homelessness or DUBE. The primary researcher had previously undertaken a 6 week placement within the charity organisation, and therefore had previously established links with some of the companions and the staff there. Three of the participants had met the researcher during this placement, which they stated made them feel more comfortable to partake in the research. It is possible that this may have affected the narrative interview, by influencing the content and form participants’ stories took and follow up questions asked by the researcher.

The researcher viewed distress through a trauma-informed lens, and felt strongly about working alongside individuals to develop meaningful understandings. The researcher held the belief that the medicalisation and illness model of distress could be potentially harmful, and professional support should offer multiple ways of making sense of their experiences. Given this, the researcher kept a reflective diary, partook in research reflexivity groups and engaged in reflexive interviews during research supervision, in order to increase awareness and consideration of how these biases and beliefs might influence the research.

Results

The results are organised by the type of analytic perspective undertaken, and therefore separated into analysis of the stories' content, form/structure and identity position. For each analytic perspective, additional supporting quotes can be found in Appendix U.

Holistic- content analysis (Lieblich, Tuval-Mashiach, & Zilber, 1998).

A holistic-content analysis of each narrative resulted in several key themes emerging from each participant's story (See Appendix R). These key themes were then synthesised to establish overall themes across stories, to understand how the previously homeless individuals made sense of their DUBE.

Overall, participants' stories seemed to span both the interpersonal and intrapersonal realms, with multiple factors considered when trying to make sense of their DUBE (See Table 2). These appeared to be interconnected – interpersonal events appeared to have intrapersonal consequences, and vice versa, for better or for worse.

Table 2. Synthesised themes and subthemes across stories, from the Holistic-Content analysis.

Theme	Subthemes
Interpersonal Factors in sense making	Trauma and Abuse
	Unresolved Loss
	Judgemental attitudes
	Fitting in: isolation vs connection
	Relational Coping
Intrapersonal factors in sense making	Physical wellbeing
	Psychological wellbeing
	Substance use
	Spiritual, Religious and Paranormal sense making
	Safety, Security and Stability

Interpersonal Factors in sense making

Relationships and connections to other people appeared to play a key role in participants' stories of sense making of DUBE. Interpersonal factors were considered at multiple levels, and were perceived as harmful, but also a resource for their future story.

Trauma and Abuse

Participants considered their childhood experiences within their stories, particularly their experiences of trauma and abuse. The inclusion of such experiences indicates participants viewed them as important when making sense of DUBE, and pertinent in conveying such sense making to the listener.

Childhood abuse featured within three participants' stories. Participants explained how these traumatic experiences resulted in anger at being let down by others, breaking the law, and the use of substances to block out painful emotions and memories:

> *"…and then the experiences I had when I was in the care system, the abuse and that what went on with that, people meant to look after me didn't look after me. That sent me off the other way and I started to break the law and all me anger and that started to come out, everything's interlinked" (Robert)*

Trauma and abuse led to mistrust of others, difficulties sleeping (and therefore physical exhaustion), feelings of paranoia and self-isolation. All of these effects of childhood trauma were discussed as key components in beginning to hear voices and develop paranoid beliefs, and also entering cycles of crime, substance misuse and homelessness:

> *"…when he was influencing my life, he drove it into me - No no one, no one, can't trust no one, not even family. We're all fucking…we're all here to hurt ya, everyone's out to hurt ya […] And that's always stuck in my head…" (Martin)*

For one participant, parental separation, witnessing inter-parental violence and extreme bullying at school was considered when making sense of feelings of paranoia and feeling 'on edge':

> *"… I'd run straight home, and walking through the village to go to my grandparents I'd take a really long walk round so I avoided certain individuals and that […] And then I got that*

paranoia, at the time, as a kid [...] that erm people were on the bus talking about me"(James)

In James' story, traumatic life experiences continued and intensified during his time in the army. He considered the impact of being repeatedly under threat, and related this to his sense of always being on edge and alert for danger, and the subsequent development of paranoia:

"*there's a lot of situations where you're being hunted down, and stuff like that, you're always watching your back, and your friends backs, all the time, constantly." (James)*

Three participants spoke of how neglect, feeling unwanted and overlooked led to a lack of direction and resulted in them following a difficult life path, punctuated by crime, drugs, prison and homelessness. Substance use was then viewed as resulting in the development of paranoid beliefs.

"And then as I've grown older, it's just not caring.. just thinking well If my mam don't care, why should I? So that's... led me to taking drugs and then obviously drugs to prison." (Harvey)

Loss

The concept of loss featured heavily in participants stories of sense making of DUBE, indicating its pivotal role. The experience of loss through the death of a loved one featured within four participants' stories. For one participant, unresolved loss and complex grief was the main way he made sense of hearing his mother's voice inside his head:

“ I think...I think personally, I put it down to about...I didn’t give myself to grief. From the death of my mum. I just put it to the side and just didn’t...[shakes head]... at all [...] I think they call it like a grieving...a um grieving voice.” (Martin)

Martin also discussed how the further loss of his daughter intensified his mother’s voice, often commenting on his life choices and situations, making it difficult to accept that his mother had gone.

Other participants considered how the loss of a loved one resulted in a substance use relapse, which they perceived as increasing their DUBE:

“And..and like losing a baby and me Dad. That was a very, very hard time, and it's really quite recent as well, not long ago and that drove me back ... and I never thought I’d go back to drugs ever again.”

(Harvey)

One participant spoke of a breakdown in familial relationships as another experience of loss. Such loss was described as leading him ‘back down the bad path’ of substance use, crime, prison and homelessness, which was later related to making sense of DUBE.

Judgemental attitudes

Perceived judgemental attitudes of others whilst homeless featured within three participants stories of making sense of paranoia and hearing voices:

> *"When I was rough sleeping, even when I was being nice to people, I was still getting the odd look…people walking past thinking 'oh he's a bum, he's a druggie, he's this that and the other…' But, I wasn't.[…] 'Cause you ask anyone these days what they think of homeless? […]druggie, drunk, smelly, doesn't bath." (Martin)*

Two participants spoke of their own past judgemental attitudes towards others, to explain their anxiety that others were doing the same to them:

> *"Like, like being younger and seeing smack heads on the streets and spitting at 'em and shit...I never thought I'd turn into one. Because I used to fuckin hate 'em when I was a kid but then obviously it backfired on me because then I became one of them and then I really understood what it was like to being to be on drugs and...what they must have felt like"(Harvey)*

Fitting in: isolation vs connection

The concept of 'fitting in' with people around them, and a subsequent sense of either connection or isolation featured in participants' stories. One participant contrasted his sense of isolation during his school years, in contrast to his time in the army:

> *"And I was always...I think as a child I was quite shy as a kid, I got bullied quite bad, especially in secondary school […]So err a lot of the time I'd keep to myself, not be open and just shy away and that…"*
>
> *"Erm, but when I joined the army I fitted in like a glove, you know it was the best thing I did." (James)*

Another participant discussed how crime became a way of ‘fitting in’ amongst his peers upon moving to a new city:

> *“We moved to a town and I started moving up the criminal ladder if that makes sense, out pinching bikes and cars and stuff. And…I think that was mainly for me to fit in though, it wasn’t because I wanted to, it was because everyone else was doing it, so I just followed suit. […] Do I walk away and be like pointed at […] or do I just go with it and fit in?”(Andrew)*

Participants also discussed the importance of connection to others for their sense of worthiness, hope and need to be noticed. Within Robert’s story, the sense of isolation experienced whilst rough sleeping played an integral role in making sense of how his voice hearing began:

> *“Yeah...I put my voices down, I think they, they started I think from being by myself, being alone, being alone, sitting in doorways talking to yourself, it does, you get to that point where you’re getting answers from nowhere…” (Robert)*

Relational Coping

Participants described the importance of spending time with other people when coping with adverse life experiences and their DUBE. Two participants discussed the role of laughter in their lives, in maintaining their psychological wellbeing and connections to other people:

> *“I think, like whenever I go somewhere new, I try and be funny. And I use my sense of humour a lot, you know to fit in and make people laugh […] cause I think laughter’s quite,*

quite important in people's lives. D'ya know, like once you can make someone laugh, you know you're halfway there." (Andrew)

Participants also discussed the role of being respected and helping others as a resident in the charity organisation, and the positive impact this had on their psychological well-being and sense of self:

"But when I've been on outreach today, speaking to homeless people and that, it was, it was amazing. Absolutely loved it and that […] I didn't feel anxious at all, or paranoid and stuff. Felt quite proud you know…" (James)

One participant discussed the importance of sometimes having alone time and some distance from other people, and termed this 'self-preservation':

"I do like spending time by myself, I could quite happy go out in the middle of nowhere, I would be happy as larry me, I would. […] cos it's like pressure cookers, everything is like build, build, build, and if you don't let that steam off, you explode. And this is my...disappearing is me opening that little valve, let a bit of steam out, give me a bit of time, and I can come back." (Robert)

Intrapersonal factors in sense making

This theme explored the internal physical and psychological processes that participants discussed within their stories of sense making of DUBE. It considered participants' wellbeing, beliefs, internal emotional experience and individual coping methods.

Physical Wellbeing

Two participants discussed their physical wellbeing when making sense of DUBE. The physical exhaustion and unmet physiological needs (food, shelter, rest) experienced whilst rough sleeping was one way in which participants made sense of DUBE:

> *"I've experienced it when I've seen things, but I put that down...through to physical exhaustion when I've been travelling the roads. It's like I've got to a stage when I'm walking through woods and I'm seeing people in trees, talking, and guiding me to where I need to be going" (Robert)*

One participant, who had spent much of his life in the army, spoke of the importance of maintaining his physical wellbeing through exercise:

> "*Doctors said to me you need to exercise, you've always been used to exercise, you've got to do it, because even if its 4, 5 times a week, just to keep yourself sane." (James)*

Psychological wellbeing

Participants discussed how their psychological well-being and sense of self related to their DUBE. One participant discussed the diagnosis of borderline personality disorder, and how he considered this to relate to his fluctuating moods, behaviours and unusual beliefs and experiences:

> *"When I when I go into these intense moods that I go into, like with my borderline personality disorder, not many people can handle having me around, you know, cause I'm very erratic, I'm very hyper. And then I'm, you know, I can't really keep my mouth shut when*

> *I'm having these experiences thinking that like I've got spirits and demons around me…"*
>
> *(Steve)*

Martin's story had a particularly strong focus on the theme of shame and guilt in relation to past actions, and he considered these painful emotions in the context of hearing his mother's voice:

> *"I didn't know, I didn't know if it was guilt. A guilt trip for me. Like […] the stuff I put her through its unforgiveable. I can understand why she rebelled against me and stuff like that […] So I just don't know if it's like a revenge voice..."*

Another participant spoke of their increased anxiety and hypervigilance following the effects of traumatic army experiences, which they related to the development of paranoid beliefs and experiences:

> *"My head goes into a bad place, and the paranoia kicks in and stuff [...] Or, I could be in the house on my own and I think someone's in there with me, and my head starts going a million miles an hour."(James)*

Participants also spoke of the impact of role loss and transition on their psychological well-being. Two participants considered depression and suicidal thoughts within their stories of sense making:

> *"I had a really bad bike accident [...] And, that, I think that was a catalyst. For me to fall backwards again. I mean I couldn't walk for 6 weeks, I was in a wheelchair. And I think, I*

got depressed [...] You start off losing one thing, and then before you know it, you're at the end of the track and you've lost absolutely everything. And that's, that's where I was."

(Andrew)

Substance use

Substance use featured heavily within five participants' stories, as they conveyed their sense making of DUBE. Participants discussed why they used substances and the impact of this on their lives, well-being and DUBE. Substance use appeared to be a way of coping with distressing interpersonal experiences, such as trauma and loss, and intrapersonal factors, such as psychological wellbeing.

Function of substances

Participants used substances to deal with grief and loss, traumatic life experiences, painful emotions, poor mental health and to fill their need to be noticed and 'seen' by others:

" I'm a man, so it's different for a man to talk about what's happened as a kid and I suppose it was just.. I never dealt with it. And that's probably one of the reasons why I turned to drugs because it was summit to try and block it out and I didn't have to think about it"

(Harvey)

One participant discussed how alcohol almost became a trusted part of their lives, after being repeatedly let down by other people:

"Alcohol has always been there for me, it's a friend, its took my worries away from me […] I need to write a letter to alcohol, cos it's a very close friend, its family, its family, it's never let me down…" (Robert)

The impact of substance use

Although substances were used as a way to cope with the loss of relationships and loved ones, they also resulted in the loss of relationships and connections for participants. One participant discussed how the use of illegal substances put his family in danger, and the impact this had on his relationship to them:

"Like in and out of jail, fucking drug dealers knocking on the door looking for me, not paying stuff like that, police coming around […] So they saw the whole lot...and the day that I walked away and said well I can't do this anymore... It's best best decision I've ever done in my whole life […]"

Substances were discussed as a way of directly understanding how and why their DUBE came to be. Three participants discussed the impact of substances in leading to and maintaining feelings of paranoia and their distressing visual experiences:

"Being homeless as well you've got nothing to lose, so you go and use drugs to try and keep keep yourself sane. But you take the wrong drugs and you see you see things […] thinking the plain clothes police are walking behind me like the drug squad and I'm stood there shouting in the middle of hospital car park, fucking get away from me man. And like now I'm clean, I understand that it was probably the drugs that I was taking […] it's got to have been...the MDMA" (Harvey)

One participant discussed how he believed substance withdrawal may have resulted in him receiving a specific mental health diagnosis by professionals, suggesting that it interferes in sense making and understanding for both the individual and the professionals around them:

"…when they diagnosed me with bipolar in jail, 16 years ago, I was actually going through a uhhhh...uhh.. heroin opiate detox. So I don't know if they got me on... just thought I'm bipolar…" (Martin)

Participants explained how substance use and homelessness can act as a barrier to accessing help and support for mental health difficulties, resulting in individuals feeling trapped within repeating cycles. For one participant, he discussed how substance withdrawal impacted the ability to attend support appointments. For another participant, supplying and using substances enabled him to access accommodation upon release from prison. This made it difficult to find a way out of substance use, given that his temporary accommodation was dependent upon his involvement in the substance use world:

"And when you're involved in that lifestyle, someone'll always put you up if they know you're earning decent money. If they know you've always got heroin or you've always got cocaine, people are willing to open their doors…" (Andrew)

Spiritual, Religious and Paranormal sense making

Spiritual and religious sense making was another key theme featuring throughout three participants stories and seemed to have key relationships with other sub-themes of loss, safety, psychological and physical wellbeing.

For one participant, their non-distressing tactile unusual experiences were made sense of in relation to the loss of a loved one:

> *"When I got touched in my back yeah, yeah, I believe that was me dad letting me know he was still around because it wasn't harmful it wasn't scary, it was just like 'I'm here son' […] But I'm a big believer in in the afterlife and spirit world." (Harvey)*

Some participants explained the way in which they had made sense of unusual experiences in the context of God/ a religious guide, which was an explanation that they found comforting, rather than distressing:

> *"…So it's happened a few times that it's like when I've had no money or anything, I've gone and sat in this certain little place, and seen little piles of money there waiting for me....and I think it's the old man upstairs looking after me in those sort of situations. It's it's...I don't know...I have got a guiding hand behind me." (Robert)*

In Steve's story, spiritual and paranormal sense-making was the main way in which he made sense of his distressing unusual experiences, and his 'spiritual gift' featured throughout his story from childhood to the present day. The imminent loss of his mother led to a developing interest in the paranormal and spiritual world:

> *"…Me and one of my friends had actually done a Ouija board, in the house, and my mum was ill at this point, she was already ill, and so I think for me I kind of did it cause I wanted to sort of access the Spirit realm to find out like what was happening…" (Steve)*

Steve explained the role other people had played in strengthening this way of making sense of his experiences:

"I remember when I was really young, she [mum] always used to say, 'you're psychic' to me, like she'd be like 'You're psychic, you're psychic."

Steve also explained how his spiritual gift can affect his psychological and physical wellbeing. Similar to Robert's story, Steve also conceptualised his spirituality as a strength and resource, specifically explaining how it helped him to cope with substance use withdrawal:

"Obviously your anatomy in your body is so crippled with pain withdrawing from this…toxic drug, It's very difficult to then tap into your spirit body and your mind body and be able to overcome it through meditation and self-hypnosis , but it is possible cause I've done it."

Psychological safety, security and stability

A sense of psychological safety, security and stability commonly featured throughout all participants stories of sense making of their distressing unusual beliefs and experiences. Traumatic experiences and others' experiences in the interpersonal realm appeared to relate to a lack of psychological safety, security and stability across various life domains. Rough sleeping was a large component in participant's experiences of feeling under threat and unsafe. Andrew explained how this related to his increased anxiety and hypervigilance:

"You've always gotta be alert and switched on. And its physically and mentally draining. Having to be alert all the time, never knowing what's gonna happen. [...] I know a lad that's had his bed set on fire. I know another person that was asleep in his tent, and they'd hooked it up to the back of a motorbike and toed his tent away whilst he was asleep in it. So, there's always that part in the back of your mind 'Am I gonna wake up alright in the morning?'. (Andrew)

Participants also discussed the impact of lacking a permanent base and secure accommodation, and explained how this influenced their sense of security, stability and confidence, which in turn they perceived as increasing their DUBE:

"The unintentional sporadicity of my life, and not being able to settle…always wondering where I'm going to end up that night, or that day you know, so I think now that I'm grounded and I'm in a better place with my mental health, it has now settled down massively. But yeah, its intense." (Steve)

Previously homeless individuals stressed the importance of establishing safety, security and stability within their living arrangements, before being able to engage in additional support around their psychological well-being and substance use. Participants also discussed how they would sometimes be allocated unsuitable and unsafe accommodation by organisations and professionals, and discussed the impact of this:

"Probation were gonna put me in the middle of the town centre [...]. Knowing full well that I was clean, I was off all the methadone, all the prescription drugs, everything. They were gonna put me in a shared house[...] living with drug addicts, prostitutes, drug dealers. I just

can't get my head round that concept, of why they'd want to put you in that area, and not try and keep ya safe." (Andrew)

Holistic – Form analysis

All six stories appeared to move through similar phases in relation to the overall tone and expression of the story and its sequence of events (See Appendix S for individual story plot graphs). All participants structured their story by beginning in childhood, then a journey through events in adulthood, and ending at the present moment. The structure and form of the story seemed to move between five phases. Phases are defined as events, experiences, emotions or actions which altered the plot of the story (Gergen & Gergen, 1987):

1. A difficult start
2. 'Up and Down' cycles
3. Having it all
4. Losing it all
5. Achieving Stability
6. An uncertain but hopeful future

For five stories, the order these phases appeared within participants' narratives was the same, and a prototypical plot graph could be created (See Figure 4). For James' story, although the same phase structure remained, it occurred in a different order (See Figure 5).

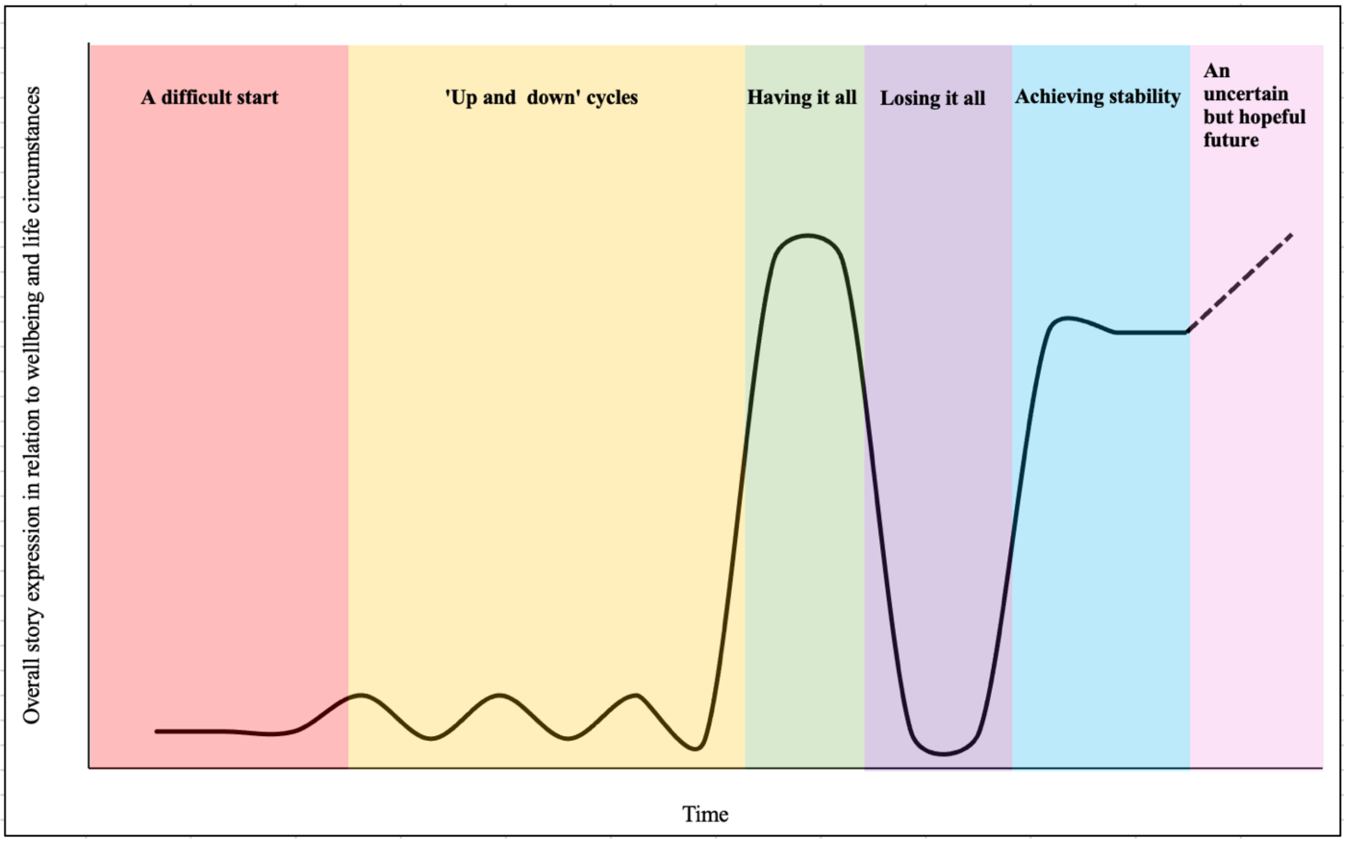


Figure 4. Plot graph depiction of the narrative form and phases for five participants.

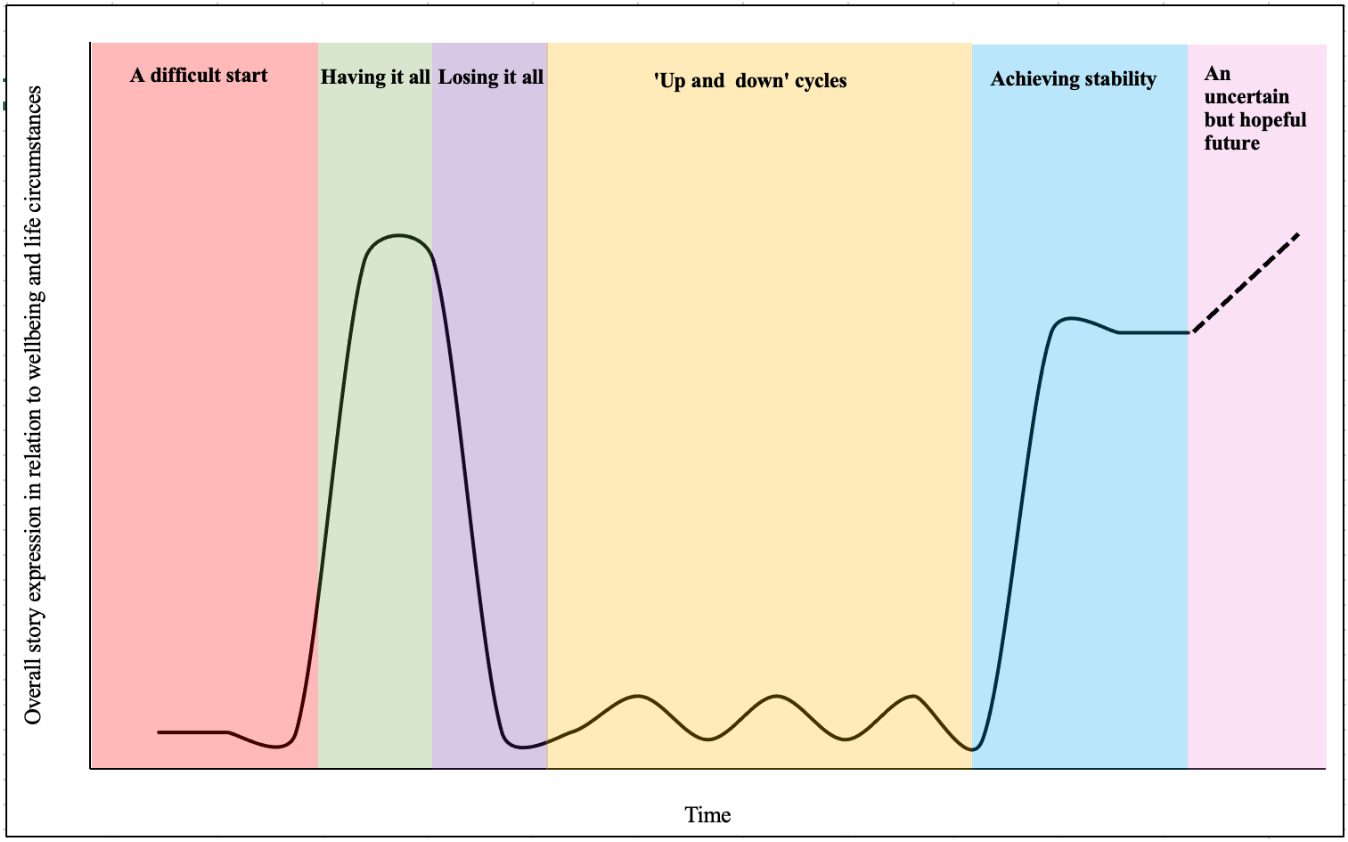


Figure 5. Plot graph depiction of the narrative form and phases for James' story.

A difficult start

For all participants, this beginning phase of their narratives was characterised by difficult and traumatic interpersonal experiences during childhood, such as loss, abuse, neglect and bullying. This phase was spoken about in terms of the intrapersonal consequences that this had, for individuals' psychological and emotional wellbeing, identities and sense of themselves:

"...at the age of 7 my parents split up [...] my father was quite abusive to my mum, err used to hit her and stuff..." (James)

'Up and Down' cycles

This phase was characterised by a sense of repeating cycles of circumstances that participants appeared to be trapped by, and struggled to find a way out of. For some, the cycles were punctuated by fluctuations in their psychological well-being, which were affected by traumatic flashbacks and distress. For others, these cycles were punctuated by the use of substances after a period of abstinence, which appeared to lead them repeatedly down a path of crime, prison, and homelessness:

"Cause my first cold turkey detox was on my 18th birthday at my mum's house. I did 14 days and 15 nights solid cold turkey, and then I got paid on the 16th day. So, I went back to square one. And it's been that cycle from being 18 years old, in prison, out of prison, been clean for probably a week, then I'd gradually fall back." (Andrew)

Some participants understood prison as forming the ‘Up’ part of the cycle, and participants spoke of how it gave them temporary relief from what occurred in the ‘Down’ trajectory of the cycle:

“They were my rest periods, when I went to jail, they were were like my rest periods, I was getting my help there, they were giving me medication to help with my drink and that, I was doing therapist groups, anger groups, that was all there to help me, it was. They were happy times, they were happy times.” (Robert)

Others discussed the role of others and their interpersonal relationships in inadvertently maintaining these cycles:

“I was still constantly on the phone asking and begging for money all the time. And she gave me it. Whereas she probably thought she was doing the right thing, as my mum and dad have throughout my life. Giving me that, to keep me out of trouble, but it never ends well…” (Andrew)

Cycles were also punctuated by a lack of stable and permanent accommodation, which often led to the re-formation of unhelpful social ties and a downward trajectory within the cycle:

“…say if I come out of custody today and I’ve got nowhere to live, you automatically go back to the part before you went into custody, you’ll probably go to the same persons house who you was living at, which is either – I’m using my own experiences – a drug user, a drinker, or that takes tablets, or that’s involved in criminality. They are really the only people you’ve got to rely on.” (Andrew)

Having it all

This phase was characterised by fond memories and a sense of physical and psychological well-being, security and safety. Participants spoke about this phase as a ‘happy period’, where they had strong connections to their families, a job, a home and a sense of purpose in life.

> *“Getting a happy period of my life when I married and got a nice little family, a decent job and everything, then losing that and then back down the bad path again [...] But I live a lot in the past, I live I have to live in my nice place, I do, I live in my happy period when I got my daughter n that round me, that’s my happy period” (Robert)*

Losing it all

Participants discussed this phase as a clear turning point in the form of their story, which was punctuated by life events such as loss, injury, divorce and eventually falling back into the use of substances as a way of coping. The form the story takes in this phase was conceptualised as going ‘back down the bad path’.

> *“...I had a really bad bike accident [...] And, that, I think that was a catalyst. For me to fall backwards again. I mean I couldn’t walk for 6 weeks, I was in a wheelchair. And I think, I got depressed. I think depression came in. And my release from that depression was obviously to go back to what I knew best, which was using drugs, and that was my way of coping.” (Andrew)*

Achieving Stability

Participants' stories often utilised a turning point in the structure of their story, which sent them on an upward trajectory resulting in the eventual achievement of this phase. Participants spoke of distressing events which acted as this turning point, leading to behaviour change:

> *"And like I've died twice...not on purpose but taking but OD'ing and I was kept alive. So obviously I was kept for a reason. So I'm meant to be here right now, if I wasn't I'd be dead, so and that's what made me start to realise that I need to sort my shit out." (Harvey)*

This phase was pivotal in changing the structure and form participants' stories took, and was discussed in terms of their present situation, as a resident in the charity accommodation. This phase was characterised by a sense of safety, consistency and security.

> *"...being here at [charity accommodation name] and that, I feel I've got that security at the moment. And I mean, If I wanted to, I could leave if I wanted to[...] but I don't want to, I've told [support worker name] and that before I'm gonna be here for a while. You know, just to, maybe a year, something like th at. Until I'm definitely, 100% sure that I can go." (James)*

An uncertain but hopeful future

This phase considered how participants' perceived the form and structure of their future stories. It was characterised by both uncertainty and hope – a hope that their future stories would take a different form than their story so far. This phase involved 'taking one day at a time' and not rushing to make changes, which could send individuals on a fluctuating trajectory.

"Just take it a day at a time…don't know...I'm not planning anything because anything can change like that, can't it. If you just live day by day and see what happens. I'm still recovering. I'm still in recovery, so there's no point trying to look forward at the moment. Because I just put too much pressure on myself, I reckon." (Harvey)

Critical Narrative Analysis – Identity Positioning

Participants appeared to adopt multiple different and inter-related identity positions during the telling of their narratives, in order to convey sense-making of DUBE and homelessness. These identity positions appeared related to both the content as well as the structure and form of the story. Overall, the various identity positions adopted by participants were broadly categorised over 3 stages – those adopted in childhood, those developed in adulthood and emerging identity positions, which were shaped by the current context (See Table 3). Within each broad category, there appeared to be conceptually similar adopted identity positions across participants' stories, which have been grouped together.

Table 3. *The different identity positions adopted throughout the narratives.*

Childhood identity positions	**Adulthood identity positions**	**Emerging identity positions**
A child who was ‘bad’ and could not be managed	*Self as flawed*	*A person with positive qualities valued by others*
A handful (Martin) Unhandleable (Steve) A black sheep (Harvey) Wayward, A drifter (Andrew)	Unworthy, ‘A bad apple’ (Robert) Insecure and Paranoid person (Martin) Attention seeking bad boy (Martin)	Adaptable, resilient, skilled (Andrew) Self as skilled and talented (Steve) Old James – confident, a joker (James)
A child unwanted and uncared for	*A person with an illness*	*A person who cares for others*
Unwanted Care Baby (Martin) Uncared for (Harvey) Uncared for (Andrew) Unwanted, given up (Robert)	A person with Bipolar (Martin) A person with Borderline Personality Disorder (Steve)	A caring person (Martin) A father figure, caring (Robert) A person who helps others (James) A person who helps others (Steve)
Vulnerable and helpless	*Self as unusual*	*A person who has agency, control and choice*
‘Done to’, Vulnerable (Harvey) Vulnerable child (James) Lacking choice, ‘done to’ by others (Martin) Helpless (Steve)	A different and invincible person (Robert) Unusual, Different from others (Steve)	A person with choice and control (Martin) A person who is taking responsibility (Robert) A person with control and power (Steve) A person with agency (Harvey) Agency and choice (James) A person with choice, power and control (Andrew)
	Additional identity positions	
	A person who unexpectedly struggled (James) Collective army identity (James	

Childhood Identity Positions

Childhood identity positions repeatedly emerged throughout the narrative into adulthood, and appeared to form the basis of additional developing identity positions.

A child who was 'bad' and could not be managed

Four participants appeared to adopt an identity position within their narratives as a child who was inherently challenging, wayward and 'bad'. Participants seemed to make sense of themselves and their experiences as others finding them 'a handful' and difficult to manage:

> *'When I was nine years old and I got put into social care, by my mum because I was a bit of a handful. My mum couldn't cope with me so she had to protect the other kids by putting me in the care basically so..." (Martin)*

Although these identity positions appeared to first be adopted when participants discussed their childhoods, analysis of the subtleties of the sjuzet revealed that they repeatedly re-emerged whilst narrating adulthood experiences and events:

> *"Not many people can handle having me around, you know, cause I'm very erratic, I'm very hyper…"(Steve)*

A child unwanted and uncared for

Four participants spoke from the identity position of being unwanted and uncared for by others, particularly their parents and main caregivers. This is how participants made sense of being in the care system. Participants discussed how this affected the form and structure their lives went on to take:

“Being not wanted was the start of my bad experiences…” (Robert)

This identity position also re-emerged later in participants narratives:

“No one who wanted me anywhere near ‘em, cos they were just like oh we've had enough of you now and they just washed their hands of me…great friends ey.” (Steve)

Vulnerable and helpless

This identity position was characterised by a sense of powerlessness, helplessness and of being at the mercy of others’ actions. There was a sense that participants viewed themselves as a person being passively ‘done to’ by others, rather than having an active role and choice in the ‘doing’.

“…we’re supposed to try and protect...and defend ourselves. But when you're a kid and someone's a lot older than you, it’s a totally different story isn’t it and it's not that simple.” (Harvey)

The continuation of the vulnerable and helpless identity position continued as the narrative progressed into adulthood, which was revealed in the words participants used when narrating their experience (Sjuzet). Participants often used phrases conveying this passive position, such as ‘I got sent too’ and ‘I got put’ when discussing feeling controlled and objectified by powerful mental health services:

"And the crisis team come out. And the next thing I know I got 4 fucking people in my cell, trying to fucking hold me down. Give me a fucking sedative to fucking calm me down. And then I got sent to err [hospital name]. Got sent there, and err saw the erm psychiatrist." (Martin)

Participants appeared to also adopt this identity position whilst narrating their experiences of homelessness and rough sleeping, which were characterised by feeling trapped and helpless*:*

"Its fucking horrible being out there. Especially if you haven't got no blankets or nowt and you're sleeping in doorways every night, you just wanna die. You just don't wanna do it anymore. And you can't see a way out." (Harvey)

Adulthood Identity Positions

Self as flawed

This identity position appeared to be related to the first childhood identity position. It appeared to position participants as having flaws located within themselves, and as being unworthy, insecure, bad and in need of attention from others, which participants positioned as negative and problematic:

"*Sometimes you get bad apples, sometimes a good one, you're a good one, I'm a bad one"(Robert)*

A person with an illness

Some participants described their experiences of having psychiatric diagnoses imposed on them, which was sometimes at odds with how participants positioned themselves in relation to DUBE**.** For some participants, they accepted this explanation of their experience and adopted it within their identities.

"When doctor did my bipolar assessment, he actually worked out there's a chemical balance in my head […] I can't make sense of it...I can't make sense of it till today...so that explanation, I've accepted." (Martin)

Self as unusual

Two participants repeatedly positioned themselves as unusual and unlike other people throughout their narratives of sense making. One participant constructed his sense of self as invincible:

"Well I used to think that I was from a different planet to you lot […] I told the jurors I was from Planet Zoltoff cos I didn't…I didn't picture myself as being like you cos I didn't need...everything I did to me… I just survived, I just survived...nothing can get me...it still can't." (Robert)

Additional identity positions

For one participant (James) there appeared to be two stand-alone identity positions, which were not conceptually similar to other participants' identity positions. This may be because James had a different structure/form to his story, and also had a distinctive experience of a long term career in the army, which appeared to greatly influence his identity when narrating his story.

James appeared to adopt a collective identity position when narrating his time in the army, which was conveyed through the changing of the way he explained his experiences by using "We" instead of "I":

> *"So erm, we did see a lot of bodies, things like that. There's obviously been a lot of deaths that have been our fault...well not our fault, but obviously what we had to do…"*
> *(James)*

James also appeared to adopt an identity position as 'A person who unexpectedly struggled', suggesting that his experiences were difficult to make sense of, and did not fit with the previous ideas he held about himself and his expected life trajectory.

> *" I feel weird, feeling like this, I've never been like it before. Especially when I was in the army days, it was just when I came out, I used to think what is wrong with me, I don't like this at all. […] I never thought I'd have to do counselling in my life or nothing like that."*
> *(James)*

The Sjuzet also revealed James positioned himself as 'unexpectedly struggling' during the live narration of his story, after becoming emotional unexpectedly.

> *"…when I was talking earlier and that, it started hitting me a little bit, and I just thought, right I'll just quickly get past this stage and tell you the next bit and that. I thought I'd be alright […] I thought I'll be okay, but then I was like shit, no, I don't..." (James)*

Emerging Identity Positions

A person with positive qualities valued by others

Towards the end of the narratives, participants appeared to begin positioning themselves differently, particularly with respects to acknowledging their positive qualities, strengths and resources, and speaking of how they were now a person who was valued by others. The charity organisation appeared to be particularly important in shaping these different identity positions and participant's sense of self. Participants positioned themselves as skilled and talented, when discussing their hope for their future stories:

"I've got so many like a multitude of skills like music, art, cooking, And I just like to be able to put my hand to things and just learn new things and train myself in different ways. And that's why I love [charity accommodation name] cos it gives you the opportunity to do that in so many different ways." (Steve)

A person who cares for others

Participants positioned themselves as caring individuals that want to help others. Participants positioned the charity organisation as a driving force in enabling them to harness and develop these values, and integrate them within their identity. For one participant, this changing identity was puzzling and difficult to make sense of:

" I'm still trying to work it out now, how I went from a selfish, arrogant 'Mr know it all' little fucker, to a person who wants to help people. And putting their feelings before my own. I really don't understand that one. I really don't. It really really puzzled me." (Martin)

A person who has agency, control and choice

Throughout the narratives of all participants as it moved towards the end phase, there was an increased sense of identity positions characterised by agency, choice, power and control, which is something that was lacking during narration of earlier parts of their stories. These moments of agency often resulted in turning points within the form and structure of the story.

".. It's showed me that if you really want something, you can...really you gotta work towards it. It don't just happen. I can't just say 'I need that, I wanna get a job and have a better life'. It's down to me to get that. Can't just expect it to come to me. I've gotta go and look for it." *(Harvey)*

Unusual experiences and beliefs themselves influenced participants' perceptions of control and power. Towards the end phases of the story, Steve positioned himself as powerful and in control, in relation to his perceived spiritual gift:

"But other things, like it seems like I can.. I can control technology sometimes like…like this, for instance, like when the Wi-Fi keeps dropping, I just say in my mind and just like focus on it and it seems to just ping up again. […] And that happens quite a lot. It's so odd, it's almost like I just have an ability of being able to tap into stuff."

Discussion

The results suggest that these participants took a holistic and whole-life approach when trying to make sense of DUBE, which is evidenced in the narratives that all began in early childhood, and ended at the present day, with a tentative final phase considering their future story. The story plots integrated interpersonal events and experiences and explored the intrapersonal consequences of such experiences, with interactions with other people often punctuating the turning points within their stories. Participants also moved between various narrative identity positions during narration, which allowed for the further construction and communication of meaning. Hearing the stories of marginalised individuals may increase understanding of how DUBE can be made sense of within the context of homelessness. Stories may be an ideal vector for communicating such sense-making to others.

Participants considered their adverse life experiences as central in the construction of meaning of DUBE. Interpersonal experiences and relationships were constructed as both harmful and helpful at different points in the narration, sending the form of their story on both upward and declining trajectories. Difficult interpersonal experiences and events forming turning points involved relationship breakdown, violence (both from and to others) and loss. The results align with the literature that suggest DUBE can be understood in the context of distressing life experiences which shape the way in which individuals perceive, understand and respond to their internal and external world (Cooke, 2017). Many of the adverse life experiences found to have a causal or strong associative relationship to the development of DUBE within the general population literature (Read et al., 2009), also featured throughout previously homeless individuals' stories, including: childhood abuse, early parental loss through abandonment and neglect, war trauma, witnessing inter-parental violence and childhood bullying. The findings also made sense in the context of the trauma model proposed by Hardy (2017), in that individuals' ways of surviving trauma may become ingrained regulation strategies. This was highlighted within James' story as he made sense of his hypervigilance and feelings of paranoia in the context of needing to be 'always watching his back', due to experiences in the army, childhood bullying and witnessing inter-parental abuse.

The findings may also be considered in the context of the Social Defeat Hypothesis (Selten & Cantor-Graae, 2005), although the study is not constructed to provide evidence to either support or refute the hypothesis itself. Participants considered their isolation, prejudice and discrimination whilst homeless and were often unable to get their core human needs met (Maslow, 1943), which may be consistent with the notion of 'social defeat' and exclusion from the majority group (Selten & Cantor-Graae, 2005). This theory suggests that the increased psychosocial stress may sensitise the mesolimbic dopamine system, which had been linked to the occurrence of DUBE and use of dopamine enhancing substances, both of which featured heavily throughout five sense-making narratives.

Participants also discussed the intrapersonal consequences of adverse life experiences when making sense of DUBE: psychological wellbeing difficulties; substance use to cope with traumatic memories and painful emotions; and a lack of security, stability, agency and control within their life stories. Participants discussed how these intrapersonal consequences resulted in difficulties maintaining a job, relationships and housing, which for some resulted in homelessness. This experience of homelessness itself maintained these difficulties for individuals with repeating patterns of compromised safety, security, stability, agency and power featuring throughout their narratives of DUBE.

Previously homeless also considered spiritual, paranormal and religious explanations when making sense of DUBE. For some, understanding DUBE as having religious or spiritual origins, either from God or a lost loved one, provided comfort and appeared to allow them to integrate DUBE within their individual identities and move forwards with their lives. This finding echoes recent research which provided evidence for the role of religion and spirituality when making sense of voice hearing in the general population, and highlighted the importance of this for the development of identity and positive coping resources (Lewis, Sanderson, Gupta & Klein, 2020).

Given the role of power, agency and control within previously homeless individuals' narratives, the Power Threat Meaning Framework (PTM; Johnstone & Boyle, 2018) may be important to consider. The findings of the current study indicate that participants intrinsically weaved the conceptual elements detailed by PTM into their stories of sense-making. The emerging themes were synthesised into Interpersonal factors (i.e., What has happened to you?), and the Intrapersonal consequences (i.e., How did it affect you? What sense did you make of it? What did you have to do to survive?). The different identity positions adopted by participants in their narratives also gives insight into the effect and meaning made from the misuse of power, and the resulting experienced threat.

Although substance use played a role within five participants stories and was considered when making sense of DUBE, participants did not consider the use of substances to be the sole explanation for their DUBE. Substance use was also constructed as a 'solution' to underlying distress, rather than the 'problem' in itself. In this way, the use of substances may be considered one type of 'Threat response' through a PTM lens (Johnstone & Boyle, 2018). Such threat responses were explained as leading to crime, relationship breakdowns, financial instability and subsequently, homelessness.

Interestingly, despite some participants having increased contact with psychiatric settings and being in receipt of diagnostic labels of mental illness, understandings characterised by illness played a minor role within participants narratives and their individual construction of meaning. Participants discussed imposed professional understandings within their narratives, but did not readily accept these as ‘truth’, and instead took a more holistic and psycho-social approach to understanding DUBE and its interactions with homelessness, that would align more with the PTM framework (Johnstone & Boyle, 2018) of understanding distress. This is also evident in the minimal identity positions adopted within narratives as ‘a person with an illness’, and instead the majority identity position is that of an individual who has experienced significant adversity.

Participants appeared to take an ‘individual complaints’ approach within their stories of DUBE (Bentall, 2006). Participants appeared to convey their understanding of DUBE through the use of individualised language within their stories. A summary of the terms used within stories when speaking about DUBE can be found in Appendix T. Individuals also used imagery within their narratives, which appeared to highlight the importance that particular event or situation had when making sense of DUBE.

Limitations

The presented study represents the voices of an extremely limited sample of six individuals, all of whom were White-British, male and from the Yorkshire region. There was limited diversity in terms of nationality, race, cultural backgrounds or gender identity. Statistics suggest that Black people are three times as likely to experience homelessness in England (Shelter, 2020); this research is missing the voices of individuals from racialised communities, who may experience homelessness and DUBE differently to this sample of White British men. It must be acknowledged that women and individuals who do not confirm to binary gender identities may also experience homelessness and DUBE differently. Intersectionality may mean such individuals experience compounded marginalisation, stigma and judgement from others in positions of power and privilege, and the opportunity for such exploration within the present study is unavailable due to the limited sample diversity. As such, there are limitations on how much can be extrapolated from the present study, which must be noted when considering the clinical implications of the present findings.

The nature of self-selecting sampling may have resulted in the recruitment of participants who were more comfortable in sharing their stories, and perhaps had previous experience of doing so. Additionally, the researcher had had some previous contact with three participants, and there was a financial incentive to take part in the study. It is possible that this may have biased participants to take part in the study, and/or potentially impacted the telling of their stories in a way that they hoped would fit with the researcher's own expectations.

The individuals who partook in the study were not currently street-homeless, and were in stable accommodation within the supportive environment of the charity organisation. As such, the findings may not reflect the experiences and sense making of individuals who are currently street-homeless and rough sleeping – this may be an area for future research. Future research may also have a theory testing and development focus, in an attempt to explore casual relationships between adverse life experiences, homelessness and DUBE.

Clinical implications

It must be noted that generalisability is not an aim of qualitative research, and so direct clinical recommendations cannot be made. In addition, the aforementioned sample limitations restrict the implications and conclusions to the specific participant demographics within the present study.

The clinical implications of the findings appear to align with the existing CHIME recovery framework which emphasises the importance of establishing connectedness, hope, identity, meaning/purpose and empowerment when moving towards psychological wellbeing (Leamy, Bird, Le Boutillier, Williams & Slade, 2011). It must be noted that generalisability is not an aim of qualitative research, and so direct clinical recommendations cannot be made. In addition, as stated as limitations,

Participants' relationship to agency, power, autonomy and choice appears to have fluctuated throughout their life stories, as indicated by the changing identity positions adopted during narration. With consideration to the PTM framework of distress (Johnstone & Boyle, 2018), clinical professionals may wish to consider power operations and misuse, and aim not to replicate previously homeless individuals' experiences of being 'done to' by others in possession of power. Instead, it may be beneficial for services to consider how clinical models can best foster choice, autonomy and agency, which these participants appeared to find helpful in moving towards a different phase in their life narratives – one of hope, safety and wellbeing. This fits with the NHS's wider agenda of trauma-informed care and moving towards greater choice and control for service users, and aligns with the CHIME recovery model (NHS, 2019a; NHS, 2019b; Leamy et al., 2011).

These participants' stories moved beyond reductionist and simplistic understandings of psychological distress characterised by medical models of 'illness', and instead appeared to take a holistic view when developing an understanding. Professionals may wish to consider such holistic views when working alongside previously homeless individuals. As demonstrated, these participants intrinsically took this whole-life approach to sense-making, and should be considered experts in their own life experiences, which aligns with the NHS Five Year Forward View (NHS, 2014). A developmental and relational perspective within formulations may wish to be explored, placing the individual's own story and sense-making at the centre. Curiosity regarding the primary difficulties underlying substance use and addiction may be helpful, rather than solely targeting substance use as the main difficulty homeless individuals face.

The present findings highlighted the importance of connection and positive interpersonal relationships for these participants, which led to 'turning points' in the form of individuals life stories, enhancing the likelihood of a positive trajectory. For these participants, establishing a sense of connection, stability and safety within situations and relationships was vital, and professionals may wish to consider this when working with individuals with experience of homelessness. Again, this maps on to the existing CHIME recovery model which also emphasises the importance of connectedness (Leamy, et al., 2011).

Participants highlighted the role of unsuitable, inconsistent and unsafe accommodation, by discussing the importance of core physiological needs, shelter and safety being met first, prior to being able to engage in work to meet their higher needs on the hierarchy (Maslow, 1943). Service professionals may wish to further consider the suitability of accommodation when supporting individuals to obtain housing. Participants explained how if housing is unsuitable and in close proximity to substance misuse activities, when attempting to meet their 'Belonging' need, (Maslow, 1943), they inadvertently form social ties within communities involved in substance use/crime, which inevitably sends them on a downward trajectory. This is in alignment with the 'Housing First' literature, which demonstrates the importance of individuals obtaining housing, prior to being required to work on substance use and other difficulties (Tsemberis, 2011; Padgett et al., 2011).

For these participants, there appeared to be a possible role for systemic interventions that strengthened community and family supports, particularly for homeless individuals and those using substances. Such interventions may be helpful to reduce feelings of isolation, disconnection and perceived judgemental attitudes. Early intervention and the identification of specialist support for children and families who have experienced loss, abuse and trauma may mitigate later intrapersonal consequences, although further research is needed that is able to be generalised.

Conclusions

Overall, the study findings indicate that this sample of White British previously homeless males take a holistic, psychosocial and whole-life approach to making sense of DUBE. They consider multiple interpersonal experience and events, and make connections to the resulting intrapersonal consequences and coping responses within their narratives. Previously homeless individuals were able to convey such sense-making through their stories, by adopting multiple and inter-related identity positions indicating the changing sense of power, agency and autonomy. The importance of language is highlighted, through the use of terms describing DUBE which reflect their own individual meaning, which should be valued by professionals.

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Part Three: Appendices

Appendices

Appendix A: Reflective Statement

Empirical Study

Developing the research

The interest in my topic area began during my community psychology placement within a residential homeless charity. When speaking to the individuals who lived there, and also whilst completing outreach shifts in the town centre, I was struck by the amount of currently or previously homeless individuals explaining their diagnoses of ‘paranoid schizophrenia’, ‘psychosis’, or recounting their experiences of hearing voices. I wondered about the nature of each of these experiences, and considered the potential relationship between the two.

My interest in psychological understandings of distressing unusual experiences and beliefs was further enhanced by my second placement, which was with one of my research supervisors within an Early Intervention Psychosis service. I recall learning about how distressing unusual experiences and beliefs could be considered as being on a continuum. For example, the experience of feeling your phone vibrating despite not actually having it in your pocket may be placed on the less distressing end of the continuum. I also recall meeting an individual who was struggling with maintaining their housing as a result of their distressing experiences, which made me wonder about how these two experiences may co-occur for individuals. When talking to Anjula and Chris at the research fair, I realised that their research interests fit well with my own, and I decided to pursue the topic area. Following this, each of the discussions I had about the research area seemed to make it feel even more ‘real’ that I was going to complete a doctorate level piece of research – this led to a mixture of excitement and anxiety about how much work it entailed!

I went on to present the research topic to 20 residents and 7 staff members within the homeless charity - the prospect of which felt daunting and anxiety-provoking. However, I felt that it was important to understand if the topic area felt relevant and important to be researched. Due to my prior relationship with the staff and residents at the charity, my nerves soon evaporated. The positive response I got about the topic area from the residents and staff was incredibly motivating and made it feel even more real!

Choosing a methodology was quite an overwhelming and stressful process, given I had no prior experience of conducting qualitative research. My reflective diary entries during this stage reflect this – "I am out of my depth with qualitative research!". Looking back at these diary entries reminds me of how far I've come in both my knowledge and skills, but also my level of self-belief. All I knew was that I wanted to amplify the voices of individuals who were often marginalised within our society, and understand more about the experience of homelessness and distressing unusual beliefs and experiences. My reading informed me that Interpretative Phenomenological Analysis (IPA) was a good approach for researchers new to qualitative research, due to widely agreed upon steps for analysis. However, when reading about narrative analysis, I came across this quote, which felt like it 'sealed the deal' – "Whereas other qualitative research methods such as interpretative phenomenological analysis (IPA) and discourse analysis tend to break the text down, a narrative researcher will try not to fragment the text, but will instead view the narrative as a whole" (Willig, 2013, p. 147). It was important to me to understand participants' stories as a whole, rather than as fragments, and so this quote particularly resonated with me. I felt excited when reading about narrative analysis, although more contained and less anxious when reading about IPA, due to it feeling more certain and systematic. I decided that as I am asking for participants' time and their stories, I should be true to what I feel passionate about, and not choose IPA simply because it felt more easily understandable. And so, I embarked on the journey of narrative analysis.

Completing the research

Until March 2020, everything seemed to be going to plan – my ethics application was in, the charity organisation were excited and on board with the research, and I was preparing to start recruitment during the Summer of 2020. However, when the COVID-19 Pandemic hit, the charity organisation became short staffed due to staff self-isolation and furlough, and understandably were not able to facilitate recruitment due to the immense pressure and uncertainty of the pandemic.

I was required to postpone recruitment until November 2020. At the time, there was so much disruption, worry and uncertainty in all areas of our lives, and so this just felt like another in a long list of things that would just have to wait! In the meantime, I got to work developing my question and search strategy on the Systematic Literature Review, which proved to be a good decision later down the line. I am incredibly fortunate and grateful that the organisation were even able to support recruitment in November 2020, as the COVID Pandemic was still meaning multiple lockdowns, restrictions and sadly severe illness and the loss of life. Due to COVID-19 restrictions, I was unable to visit the organisation in person during the recruitment process as I had planned, and had to heavily rely on the support workers there to inform the residents about the research. I did experience some guilt about them having to do some of the work that I had planned to do myself. The support workers were fantastic in passing along interested participants' details to me so that I could then contact them to discuss the research further. The support workers played a huge part in recruitment, and also facilitated the remote interviews by lending residents their work laptops – I am incredibly grateful for their help throughout the process.

The research interviews themselves were also changed by the pandemic, in that they all had to be completed via a video call rather than in person. Participants frequently commented how they would have preferred to take part face to face in an ideal world, and we both expressed how strange it felt that this was not possible. Luckily, for most of my interviews, the technology and Wi-Fi connection did not let us down. Unfortunately one interview was really affected by poor connection and the audio kept dropping out. I felt frustrated and anxious in the moment, and was also concerned that I was missing parts of the participant's story. Despite some frustrations with technology, I feel extremely lucky that I was able to still complete high quality and rich interviews with participants, and grateful that the technology exists and that I have access to it. This made me reflect on my privilege, in that I could easily keep connected through my laptop and phone, both during my research but also in my personal life.

Having the privilege of hearing participants' stories during the interviews was undoubtably the most enjoyable part of the research process – all the work I had put in previously felt like it really came alive! This renewed my passion and enthusiasm for the project, which was very beneficial when it came to the process of analysis and writing up.

Writing up

On reflection, I think this stage challenged me the most. I experienced a lot of self-doubt that I was not intelligent enough to complete the biggest piece of work of my life, and at times it felt like a mountain that I was not able to climb. Trying to understand how to do narrative analysis was incredibly overwhelming and difficult - my 'unrelenting standards' schema was very active! I felt a lot of internal pressure to do the participants' stories justice within my analysis and write up – they had trusted me to amplify their voices, and I felt worried that I would not be able to do this well enough. At times, I was very close to throwing narrative analysis out completely and returning to the structured steps of IPA that I had previously considered! However, I persevered, and after printing many papers and using 2 packs of highlighters, I felt that I 'got it' enough to begin analysing the data. The actual transcript analysis was enjoyable and incredibly interesting – I loved repeatedly reading the stories I had been told and getting an understanding of participants' life journeys. I also feel proud that I immersed myself in a less frequently used methodology for doctoral theses – I feel this tested me, but ultimately it has paid off.

The last three months before submission were extremely tough. I experienced constant feelings that there just was not enough time, and repeatedly became overwhelmed with just how long everything was taking. I missed the very optimistic (and probably unrealistic) deadlines that I had set for myself, and had to try very hard not to listen to my inner critic about this! The loss of weekends and doing activities I enjoyed was tough – it seemed like there was no time to go to the gym, cook, see family and friends, go shopping…all the things that made me…me!

However, the continuous support, encouragement and positive feedback from my supervisors pulled me through. They seemed to have complete faith in me, even when I felt that writing a thesis was beyond my capabilities. Receiving positive feedback on the first drafts of both papers was a moment where I really felt that I had done it! I remember feeling surprised that I did not receive more extreme corrections and adjustments to make. Anjula consistently told me that I had something important to say with this research, which I held on to during the tricky times. Slowly, I began to realise that I was capable of writing a thesis that conveyed an important message.

In the future, when completing research but also beyond, I have learned that I must just keep putting one foot in front of the other. I have learned that if I look at things as a complete whole, I get overwhelmed and go into ‘threat mode’. I have a lot more faith in myself and my abilities than I did before starting this piece of research, and feel confident that this is something that will stay with me throughout my career in clinical psychology.

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Appendix B: Epistemological Statement

It has been suggested that 'Epistemology is inescapable', in that all research inherently involves knowledge creation, which therefore demands a theory of knowledge and its creation (Carter & Little, 2007, p. 5).

Within this research, the epistemological position of the researcher is that of critical realism (Bhaskar, 1978). Critical realism distinguishes between the 'real' and the 'observable' world, and suggests that there is a 'real' world that exists independently of our perceptions and interpretations – although this cannot be observed (Maxwell, 2012). Critical realists suggest that our understanding of this world is socially constructed, and influenced by our own position, experiences and individual interpretations. As such, this epistemological position lends itself to narrative inquiry as a methodology, as it assumes a connection between what a person says, and how they view themselves, others and the world around them (Crossley, 2007). Critical realism also assumes that a person's subjective experience of phenomena can be explored through the language they use and the content of the stories they tell, fitting with the research aim, questions and methodology.

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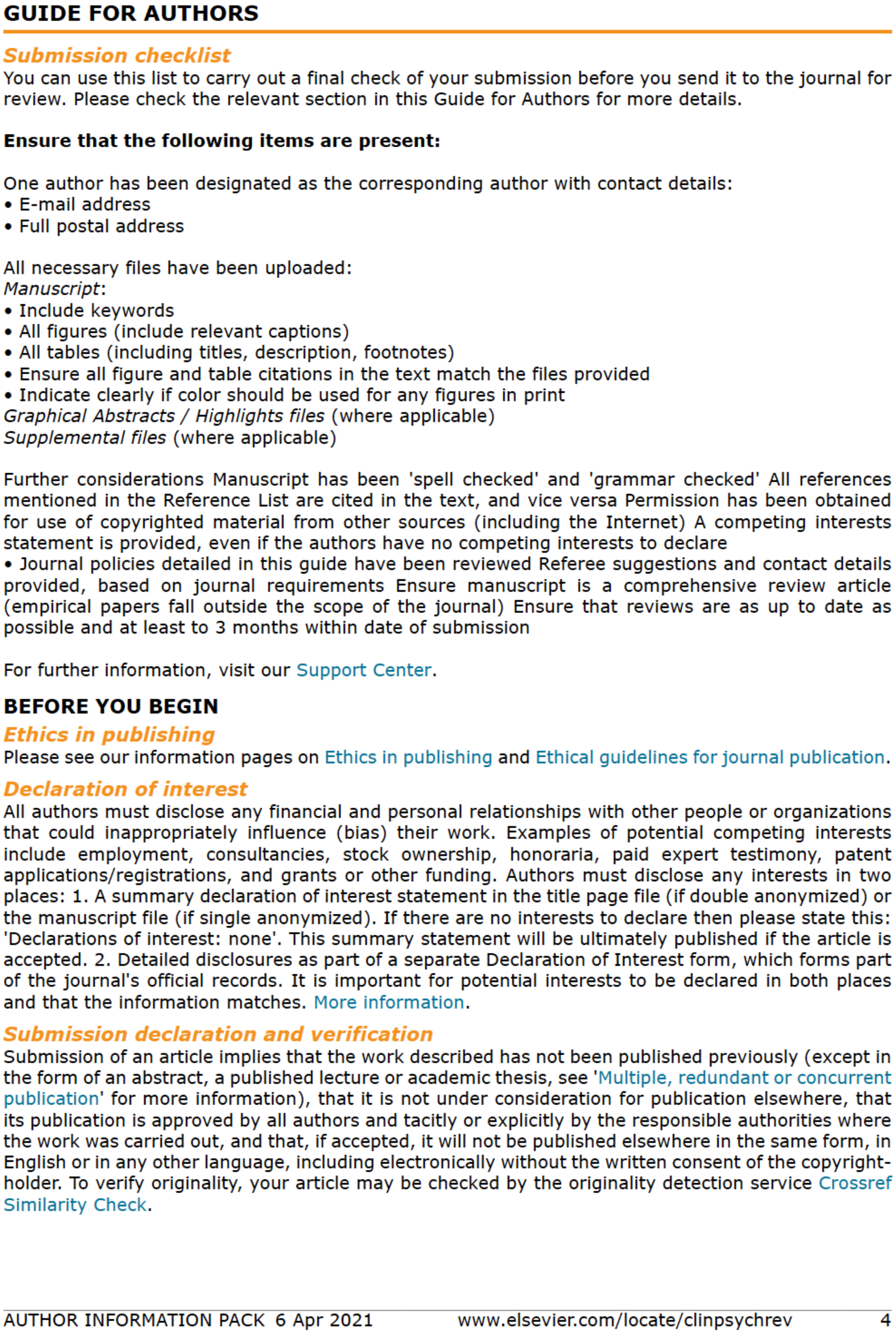
Appendix C: Clinical Psychology Review submission guidelines



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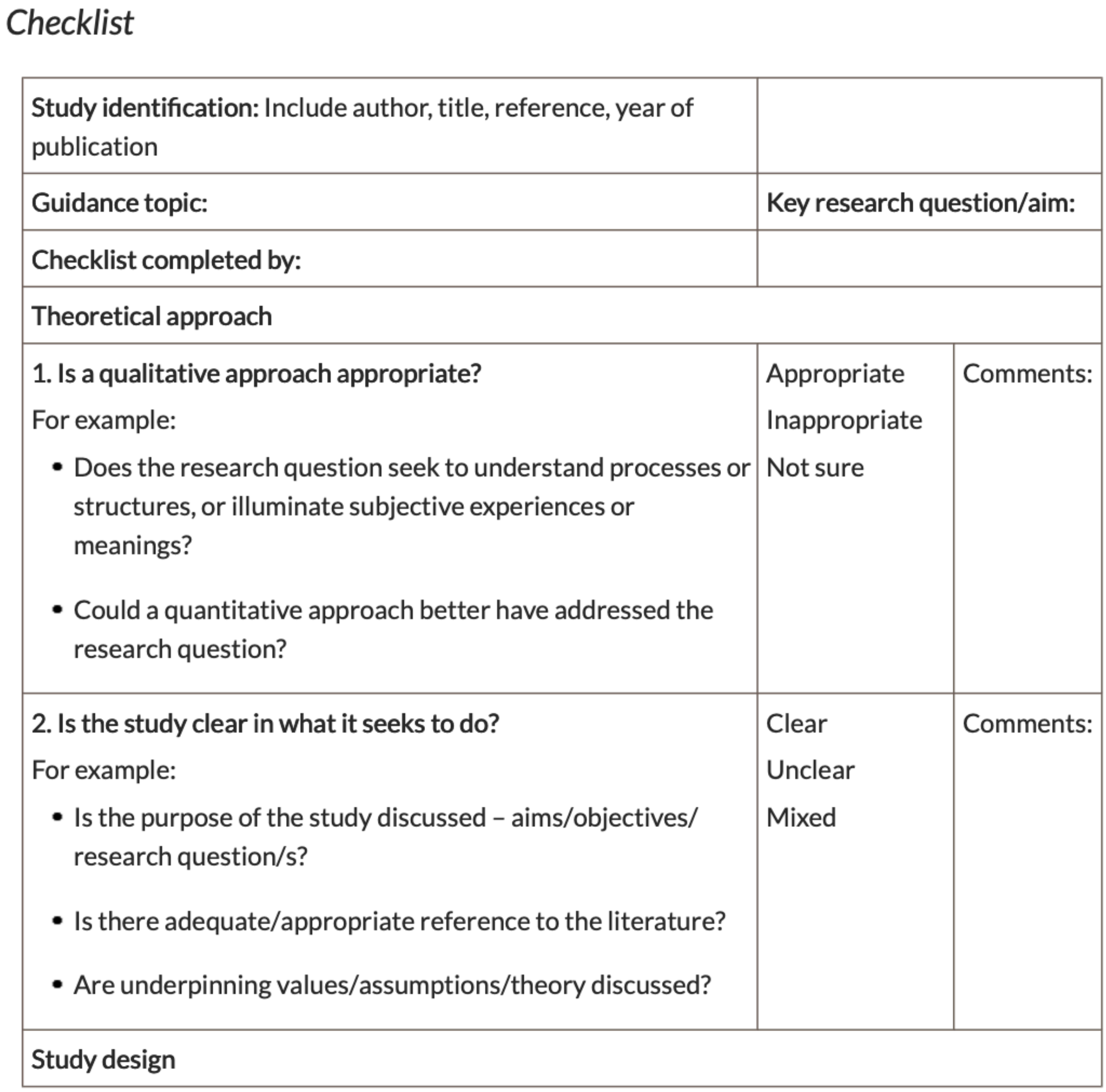
Appendix D: Blank Data Extraction Form

Author (year)	Aims	Location	Methodology	Participants (Size, Age, Gender, Ethnicity, Socio Economic Status)	Key Findings	Conclusions	Quality rating

Appendix E: NICE Quality appraisal checklist for qualitative studies



Checklist

Study identification: Include author, title, reference, year of publication		
Guidance topic:	**Key research question/aim:**	
Checklist completed by:		
Theoretical approach		
1. Is a qualitative approach appropriate? For example: • Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings? • Could a quantitative approach better have addressed the research question?	Appropriate Inappropriate Not sure	Comments:
2. Is the study clear in what it seeks to do? For example: • Is the purpose of the study discussed – aims/objectives/ research question/s? • Is there adequate/appropriate reference to the literature? • Are underpinning values/assumptions/theory discussed?	Clear Unclear Mixed	Comments:
Study design		

3. How defensible/rigorous is the research design/ methodology? For example: • Is the design appropriate to the research question? • Is a rationale given for using a qualitative approach? • Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used? • Is the selection of cases/sampling strategy theoretically justified?	Defensible Indefensible Not sure	Comments:
Data collection		
4. How well was the data collection carried out? For example: • Are the data collection methods clearly described? • Were the appropriate data collected to address the research question? • Was the data collection and record keeping systematic?	Appropriately Inappropriately Not sure/ inadequately reported	Comments:
Trustworthiness		
5. Is the role of the researcher clearly described? For example: • Has the relationship between the researcher and the participants been adequately considered? • Does the paper describe how the research was explained and presented to the participants?	Clearly described Unclear Not described	Comments:

6. Is the context clearly described? For example: • Are the characteristics of the participants and settings clearly defined? • Were observations made in a sufficient variety of circumstances • Was context bias considered	Clear Unclear Not sure	Comments:
7. Were the methods reliable? For example: • Was data collected by more than 1 method? • Is there justification for triangulation, or for not triangulating? • Do the methods investigate what they claim to?	Reliable Unreliable Not sure	Comments:
Analysis		
8. Is the data analysis sufficiently rigorous? For example: • Is the procedure explicit – i.e. is it clear how the data was analysed to arrive at the results? • How systematic is the analysis, is the procedure reliable/ dependable? • Is it clear how the themes and concepts were derived from the data?	Rigorous Not rigorous Not sure/not reported	Comments:

9. Is the data 'rich'? For example: • How well are the contexts of the data described? • Has the diversity of perspective and content been explored? • How well has the detail and depth been demonstrated? • Are responses compared and contrasted across groups/ sites?	Rich Poor Not sure/not reported	Comments:
10. Is the analysis reliable? For example: • Did more than 1 researcher theme and code transcripts/ data? • If so, how were differences resolved? • Did participants feed back on the transcripts/data if possible and relevant? • Were negative/discrepant results addressed or ignored?	Reliable Unreliable Not sure/not reported	Comments:
11. Are the findings convincing? For example: • Are the findings clearly presented? • Are the findings internally coherent? • Are extracts from the original data included? • Are the data appropriately referenced? • Is the reporting clear and coherent?	Convincing Not convincing Not sure	Comments:
12. Are the findings relevant to the aims of the study?	Relevant Irrelevant Partially relevant	Comments:

13. Conclusions For example: • How clear are the links between data, interpretation and conclusions? • Are the conclusions plausible and coherent? • Have alternative explanations been explored and discounted? • Does this enhance understanding of the research topic? • Are the implications of the research clearly defined? **Is there adequate discussion of any limitations encountered?**	Adequate Inadequate Not sure	Comments:
Ethics		
14. How clear and coherent is the reporting of ethics? For example: • Have ethical issues been taken into consideration? • Are they adequately discussed e.g. do they address consent and anonymity? • Have the consequences of the research been considered i.e. raising expectations, changing behaviour? • Was the study approved by an ethics committee?	Appropriate Inappropriate Not sure/not reported	Comments:
Overall assessment		
As far as can be ascertained from the paper, how well was the study conducted? (see guidance notes)	++ + –	Comments:

Appendix F: Summary of quality assessment checklist ratings

	Checklist Item													
Paper	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Grade
Taylor, Stuttaford, Broad, & Vostanis (2007)	Appropriate	Clear	Defensible	Appropriately	Clearly Described	Clear	Not Sure	Rigorous	Not Sure	Not Sure/ Unreported	Convincing	Relevant	Adequate	Appropriate	++
Darbyshire, Muir-Cochrane, Fereday, Jureidini, & Drummond (2006)	Appropriate	Clear	Defensible	Appropriately	Clearly Described	Clear	Reliable	Not Sure/Not Reported	Rich	Not Sure/ Unreported	Convincing	Relevant	Adequate	Appropriate	++
Huey, Fthenos, & Hryniewicz (2013)	Appropriate	Clear	Defensible	Appropriately	Unclear	Clear	Reliable	Rigorous	Rich	Reliable	Not Sure	Relevant	Adequate	Not sure/not reported	++
Padgett, Henwood, Abrams, & Davis (2008)	Appropriate	Mixed	Defensible	Appropriately	Not Described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Pahwa, Yuan, Padgett, & Smith, (2019)	Appropriate	Clear	Defensible	Appropriately	Clearly Described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Not sure/not reported	++
O'Reilly, Taylor, & Vostanis (2009)	Appropriate	Clear	Defensible	Appropriately	Not described	Clear	Reliable	Not Sure/Not reported	Rich	Not sure/not reported	Convincing	Relevant	Adequate	Not sure/not reported	+

Kerman, Gran-Ruaz, Lawrence, & Sylvestre (2019)	Appropriate	Clear	Defensible	Appropriately	Not described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Not sure/not reported	++
Bhui, Shanahan, & Harding(2006)	Appropriate	Clear	Defensible	Appropriately	Not described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Watson (2012)	Appropriate	Clear	Defensible	Appropriately	Not described	Unclear	Reliable	Not sure/not reporter	Rich	Not sure/not reported	Convincing	Relevant	Adequate	Not sure/not reported	+
Huey, Fthenos, & Hryniewicz (2012)	Appropriate	Clear	Defensible	Appropriately	Unclear	Clear	Reliable	Rigorous	Rich	Reliable	Not sure	Relevant	Adequate	Not sure/not reported	+

Appendix G: Key characteristics of reviewed papers.

Author (year)	**Location/ Service Setting**	**Methodology**	**Participants**	**Key Findings**	**Quality rating**
Taylor, Stuttaford, Broad, & Vostanis (2007)	United Kingdom A specific mental health service within a homeless shelter – 'In House'	Thematic Analysis Semi-structured interviews	19 young people: - 13 female - 6 male Age 16 – 23 (Mean = 19)	2 broad themes emerged, with 10 sub-themes: **1. <u>Experience of new Strong Minded mental health service</u>** a.) **Referral process** b.) **Engagement** c.) **Comparison to other counselling or services** – 'less clinical' setting enabled service users to feel more relaxed and comfortable. **2. <u>Aspects of Strong Minded service that contributed to perceived effectiveness</u>** a.) **Confidentiality** b.) **Mental Health coordinator not being a member of hostel staff** c.) **Offering in-house services**. d.) **Telephone contact** e.) **Meeting outside of the hostel**. f.) **Supporting referral to other agencies** g.) **Outreach work**	++
Darbyshire, Muir-Cochrane, Fereday, Jureidini, & Drummond (2006)	Adelaide, Australia A range of mental healthcare services (hospital, community, public, and private)	Thematic Analysis Qualitative Interviews	10 young people: - 7 female - 3 male Age 16 - 24	**<u>Perceptions of current healthcare services</u>** 1. **Labelling** – perceived stigma 2. **'Drive-by' assessment** 3. **Lack of explanations** 4. **Lack of personal control** 5. **Public versus private facilities** 6. **Coordination between services** **<u>Positive aspects of care which enhanced engagement</u>** 1. **'I felt like I mattered'** – 'small acts of kindness'	++

				2. **People who actually listened** 3. **Having a non-judgemental approach**	
Huey, Fthenos, & Hryniewicz (2013)	Detroit, Chicago (United States of America) Mental Health Counselling Services	Mixed methods – Qualitative component was Grounded Theory Semi-structured interviews	60 Homeless Women. Ethnicities: - 49 African American - 6 Caucasian - 3 Latina - 1 Native American - 1 Pacific Islander Ages: 18 – 70	• 52 participants self-identified as resilient, 6 identified as vulnerable/weak and 2 had mixed feelings about their level of resilience. **Positive attitudes towards mental health counselling** • Women who self-identified as strong or resilient -counselling was helpful for personal growth and to secure housing. • Four women identifying as 'vulnerable/weak'- counselling may be valuable to help them resolve trauma. • The 2 women with 'mixed feelings' about their resilience - mental health counselling may be beneficial to help them 'let go'. **Negative attitudes towards mental health counselling** • One third of women identified counselling as unhelpful or held mixed views. Factors mentioned were:- - Timing - Emotional and psychological risks - Fear it may 'side-track' them lives – basic survival took priority - Resentment for 'mandated counselling' - Trust difficulties **Mixed reviews towards mental health counselling** • Unsatisfactory personal experiences. • Interventions to be offered at the shelter, and fit with other priorities.	+
Padgett, Henwood, Abrams, & Davis (2008)	New York, United	Grounded Theory	39 formerly homeless adults with mental health difficulties (67% male, 33% female)	A Grounded Theory Model of engagement and retention: **2 Person Centred factors:**	+

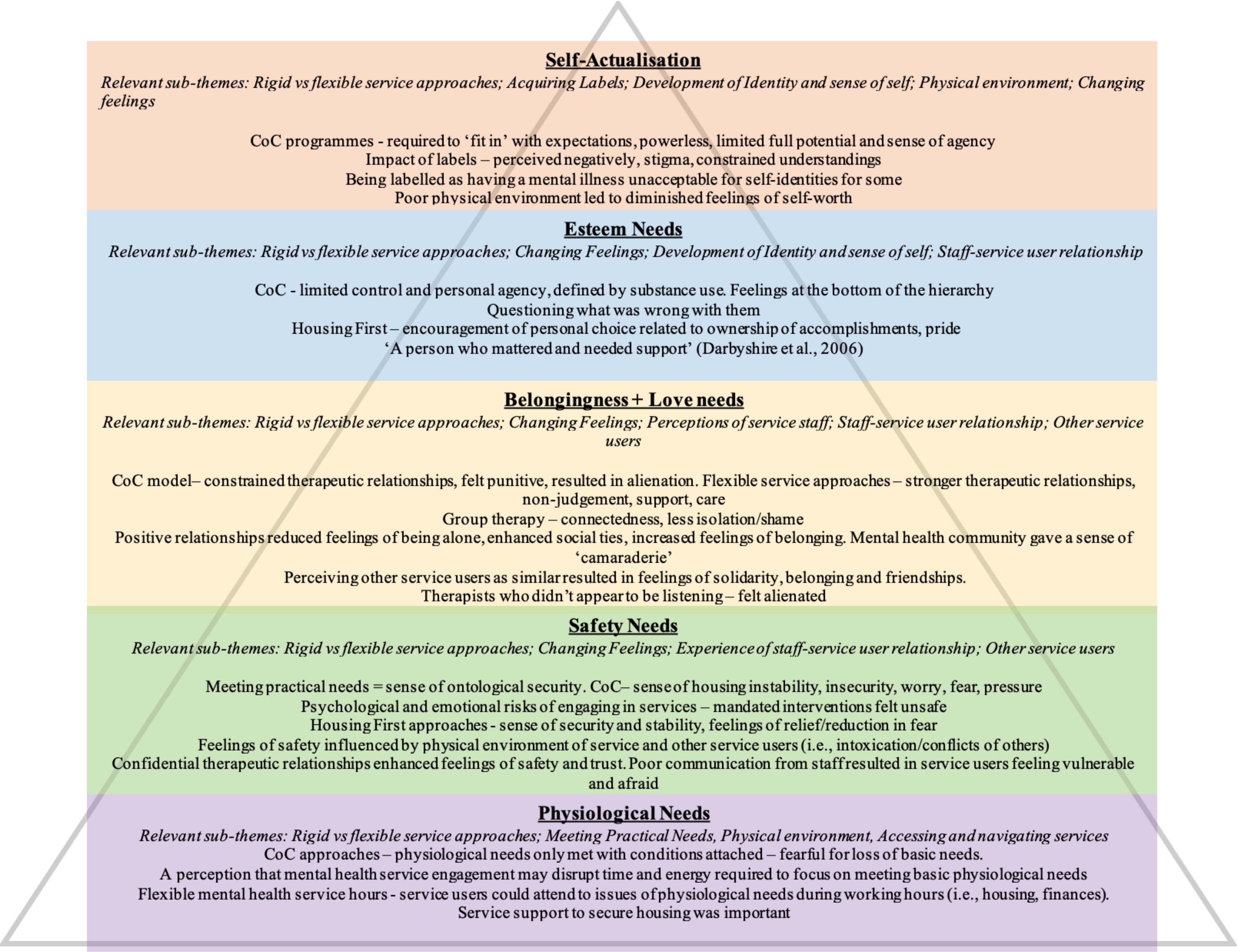
	States of America Mental health and substance abuse services (community and hospital settings)	Semi-structured qualitative interviews		- **Mental illness severity** (positive influence on engagement and retention) - **Substance abuse** (Negative influence) **<u>5 system-related factors:</u>** - **Acts of Kindness** (Positive influence) - **Access to Housing** (Positive influence) - **Pleasant Surroundings** (Positive influence) - **Lack of One-on-One** (Negative influence) - **Rules and Restrictions** (Negative influence). Person centred factors were related to engagement and retention outcomes directly, but also through interaction with System factors.	
Pahwa, Yuan, Padgett, & Smith, (2018)	Large north-eastern city in the United States of America. Mental health and substance abuse services	Grounded Theory and Cross-Case Analysis Semi-structured interviews	34 formerly homeless individuals (26 men/ 8 women) - Age 29 – 73 (mean = 52) - Ethnicities: (64% Black; 15% White; 9% Hispanic; 6% Native American; 3% Asian American ;and 3% Native American/Cuban)	Grounded theory model was developed, but only elements of it were relevant to the review question, which are highlighted with an asterix. 2 broad themes regarding social ties: 1. **<u>Ties that bind</u>** - **Supportive family ties** - **Ties to cultural spaces** - ***Camaraderie – ties to the mental health service community** - **Ties to employment – giving back/ getting respect** 2. **<u>Obstacles that 'get in the way' of social ties</u>** - **Mental health symptoms** - **Avoiding substance-using peers** - **Stigma** - **Loss of family ties**	++
O'Reilly, Taylor, & Vostanis (2009)	England A specific mental health service within a	Discourse Analysis Semi-structured interviews	- 25 young people *Age 15-22 (Mean= 17.3). 17 female, 8 male.* - Staff sample: 12 shelter staff and 5 mental health	- 4 key themes: - **Denial of mental health problems** - **Negative perceptions of mental health –** - **Value of having someone to talk to –** - **Challenging prejudice** (*note: this theme is discussed from the staff member's perspectives and therefore is not included in the present review).*	+

	homeless shelter – 'In House'		coordinators. *(not relevant to the focus of the review question)*		
Kerman, Gran-Ruaz, Lawrence, & Sylvestre (2019)	Canadian City (Mid-Size) Health, Social and Community Services (inclusive of mental health services)	Thematic Analysis Semi-structured qualitative interviews	• 52 adults (over 18) (53.8% female, 44.2% male, 1 person transgender female). • 26 were Formerly Homeless (Mean age = 47.62) • 26 were currently homeless (Mean age = 41.85). • All self-reported a mental illness or substance abuse problem	• 5 themes emerged with several sub themes: **1.) <u>Accessibility of services</u>** 1a.) Eligibility 1b.) Information and direction 1c.) Program Capacity 1d.) Proximity 1e.) Affordability **2.) <u>Humanity in Approach to Care</u>** 2a.) Organisational rules and policies 2b.) Characteristics and approach of service providers **3.) <u>Perceptions and relationships with other service users</u>** 3a.) Safety and security 3b.) Relatability 4a.) Quality 4b.) Atmosphere **4.) <u>Outcomes of service use</u>** 5a.) Feelings 5b.) Met or unmet basic needs	++
Bhui, Shanahan, & Harding(2006)	East London, UK Health Services	Semi-structured interviews Framework Analysis	• 10 homeless people with self-identified mental health difficulties (e.g. diagnosis of schizophrenia, psychosis, depression, post-	7 broad themes established: - **Health and biography** - **Stigma** – Staff often hold stereotypical views - **Service provision** –Specific mental health services rarely mentioned - **Coping** – Having a place to go during crisis - **Finances**	+

	(inclusive of mental health services)		traumatic stress, substance abuse). • 6 male, 4 female (Age range = 19 – 54) • Nationalities: (5 UK; 1 English; 1 USA; 2 Somali; 1 Sudanese)	- **Hostels** – Rules authoritarian service approaches perceived negatively. - **Service improvement recommendations**	
Watson (2012)	A midwestern city in the USA Mental Health Services in Community Residential Settings Housing First Services vs. Continuum of Care Services	Integrated study design: Case Study and Grounded Theory Focus group and Interviews	• 60 staff and service users were interviewed (Service user only perspectives included for the review) • 24 service users in a focus group, and 21 were interviewed. • All service users had a dual diagnosis (Serious mental illness and substance use disorders).	**<u>Continuum of Care Experiences</u>** • **Structural Chaos -** Limiting consumer's individual agency, powerlessness • **Rationalisation and Alienation –** negative impact on relationships **<u>Housing First Model Experiences</u>** • **The Power of Consumer Choice** • **Flexible Programming and Housing Security** • **Positive effects on consumer-staff relationships**	+
Huey, Fthenos, & Hryniewicz (2012)	Detroit and Chicago, USA Mental Health Counselling	Content Analysis and Thematic Analysis Informed by pre-existing data collected	• 79 Homeless Women (Ages 18 – 70) • 81% were African American; 12% were Caucasian; 4% were Latina, 1 participant was Native American and 1 was Pacific Islander.	**<u>Accessing Mental Health Services</u>** • Lack of information and knowledge • Lacking transport means • Fear of being viewed as 'crazy' • Distrust of counselling and/or believing it would not be useful • Failure to develop a detailed case history that would reveal trauma **<u>Consuming Mental Health Services</u>**	+

	as part of a larger study. 101 Semi-structured interviews 2 Stages – Results of first stage of research informed development of the interview checklist used in second stage.	• Diverse range of experiences of homelessness, from 1 week up to decades of cyclical periods of homelessness. • All had significantly stressful life events occur, with the majority experiencing more than one. (67 women reported one or more symptoms of trauma.)	• The majority of women reported some positive benefits • Limitations: Women not asked about their histories of trauma • Provision of inappropriate treatment • Service users feeling alienated from counsellors • Receiving overdiagnoses/misdiagnoses, missing the wider context

Appendix H: Visual depiction of how the findings of the review may align with Maslow's hierarchy of needs (Maslow, 1943).



Self-Actualisation

Relevant sub-themes: Rigid vs flexible service approaches; Acquiring Labels; Development of Identity and sense of self; Physical environment; Changing feelings

CoC programmes - required to 'fit in' with expectations, powerless, limited full potential and sense of agency
Impact of labels – perceived negatively, stigma, constrained understandings
Being labelled as having a mental illness unacceptable for self-identities for some
Poor physical environment led to diminished feelings of self-worth

Esteem Needs

Relevant sub-themes: Rigid vs flexible service approaches; Changing Feelings; Development of Identity and sense of self; Staff-service user relationship

CoC - limited control and personal agency, defined by substance use. Feelings at the bottom of the hierarchy
Questioning what was wrong with them
Housing First – encouragement of personal choice related to ownership of accomplishments, pride
'A person who mattered and needed support' (Darbyshire et al., 2006)

Belongingness + Love needs

Relevant sub-themes: Rigid vs flexible service approaches; Changing Feelings; Perceptions of service staff; Staff-service user relationship; Other service users

CoC model– constrained therapeutic relationships, felt punitive, resulted in alienation. Flexible service approaches – stronger therapeutic relationships, non-judgement, support, care
Group therapy – connectedness, less isolation/shame
Positive relationships reduced feelings of being alone, enhanced social ties, increased feelings of belonging. Mental health community gave a sense of 'camaraderie'
Perceiving other service users as similar resulted in feelings of solidarity, belonging and friendships.
Therapists who didn't appear to be listening – felt alienated

Safety Needs

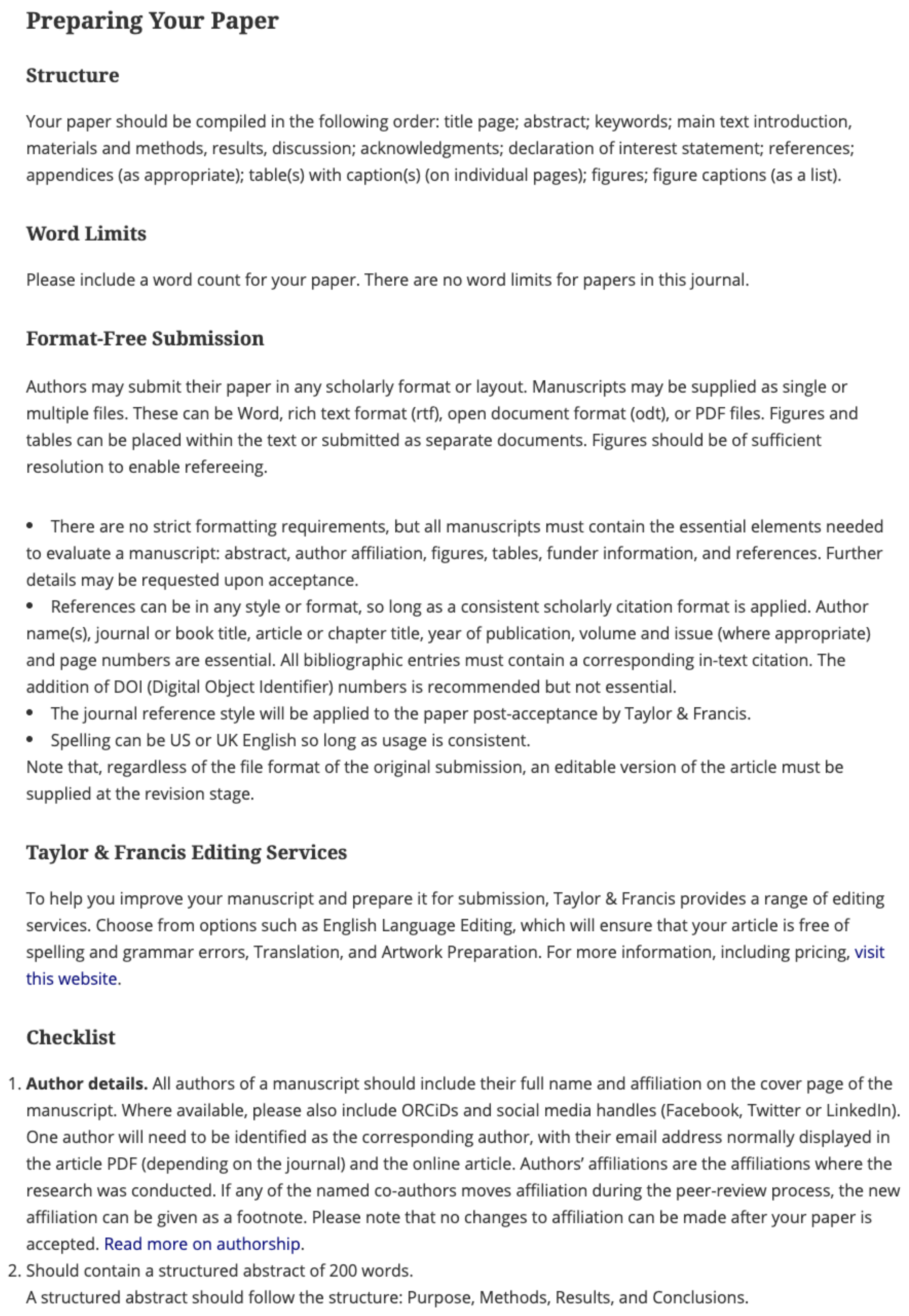
Relevant sub-themes: Rigid vs flexible service approaches; Changing Feelings; Experience of staff-service user relationship; Other service users

Meeting practical needs = sense of ontological security. CoC– sense of housing instability, insecurity, worry, fear, pressure
Psychological and emotional risks of engaging in services – mandated interventions felt unsafe
Housing First approaches - sense of security and stability, feelings of relief/reduction in fear
Feelings of safety influenced by physical environment of service and other service users (i.e., intoxication/conflicts of others)
Confidential therapeutic relationships enhanced feelings of safety and trust. Poor communication from staff resulted in service users feeling vulnerable and afraid

Physiological Needs

Relevant sub-themes: Rigid vs flexible service approaches; Meeting Practical Needs, Physical environment, Accessing and navigating services
CoC approaches – physiological needs only met with conditions attached – fearful for loss of basic needs.
A perception that mental health service engagement may disrupt time and energy required to focus on meeting basic physiological needs
Flexible mental health service hours - service users could attend to issues of physiological needs during working hours (i.e., housing, finances).
Service support to secure housing was important

Appendix I: Submission guidelines for the International Journal of Qualitative Studies on Health and Wellbeing



Preparing Your Paper

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

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- References can be in any style or format, so long as a consistent scholarly citation format is applied. Author name(s), journal or book title, article or chapter title, year of publication, volume and issue (where appropriate) and page numbers are essential. All bibliographic entries must contain a corresponding in-text citation. The addition of DOI (Digital Object Identifier) numbers is recommended but not essential.
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Checklist

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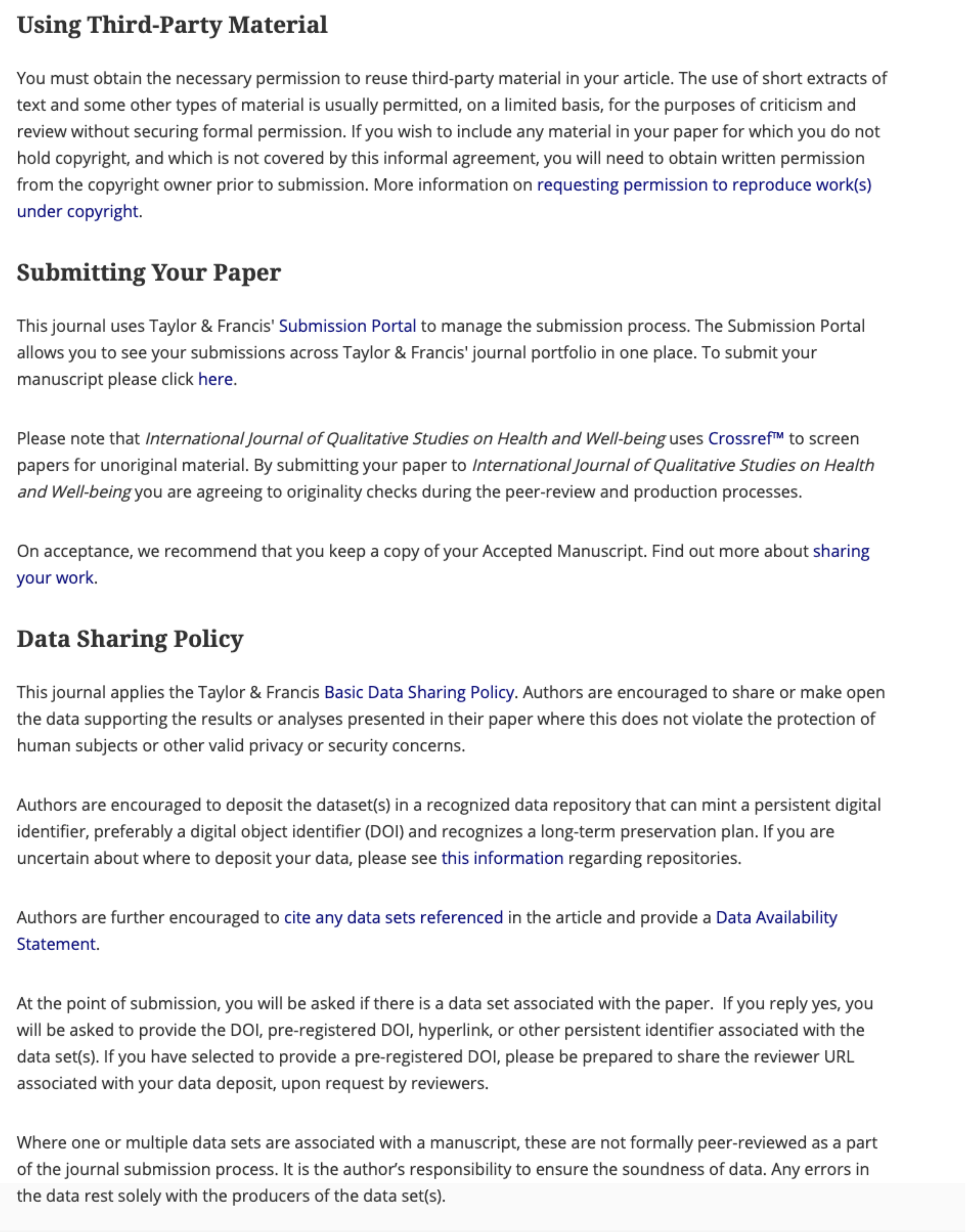
2. Should contain a structured abstract of 200 words.
   A structured abstract should follow the structure: Purpose, Methods, Results, and Conclusions.



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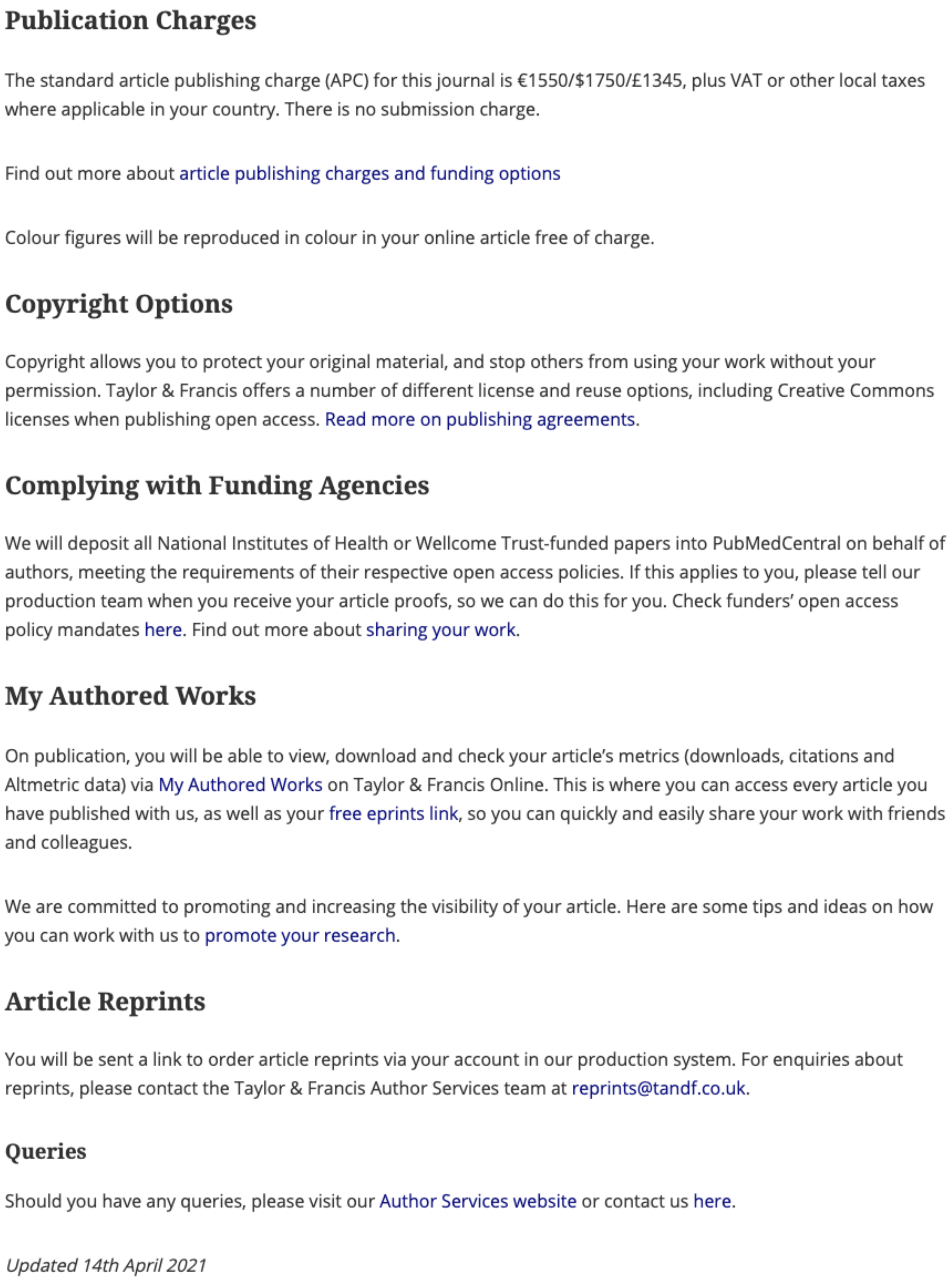

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Updated 14th April 2021

Appendix J: Narrative interview introductory statement

"As you are aware, the conversation we are about to have will form part of a research project, which is trying to understand the experiences of being homeless and having also experienced distressing unusual beliefs and experiences. 'Unusual experiences' are a term used to describe seeing, hearing, tasting, smelling or feeling experiences which others do not commonly experience, for example hearing voices that others cannot hear. By 'unusual beliefs', I mean holding beliefs that other people do not share, for example believing other people may be trying to harm you, or that you are being followed. However, some people use other words to describe these experiences, for example 'hallucinations', 'delusions' or 'paranoia'. I encourage you to describe your experiences using words that fit for you. The research is interested in how you explained your unusual experiences and/or beliefs when they first began, and how this might have changed over time. We are also interested in if you believe these unusual experiences are connected to homelessness, and if so, how you think they may be related. The interview will ask you to speak freely about your story, and you may give as much or as little detail as you wish. You can decide where you begin your story, and what you choose to include. When you have finished telling your story, you may be asked some follow-up questions to explore some parts of your story in more detail."

Appendix K: Ethical Approval Letter

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Appendix L: Advertisement Poster

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WOULD YOU LIKE TO CONTRIBUTE TO RESEARCH?

Participants are needed for a research study!

We are trying to understand more about homelessness and "Distressing unusual experiences and beliefs" (seeing, hearing, tasting, smelling or feeling experiences which others do not, for example hearing voices that others cannot hear, or holding beliefs that other people do not share.)

PARTICIPANT REQUIREMENTS:

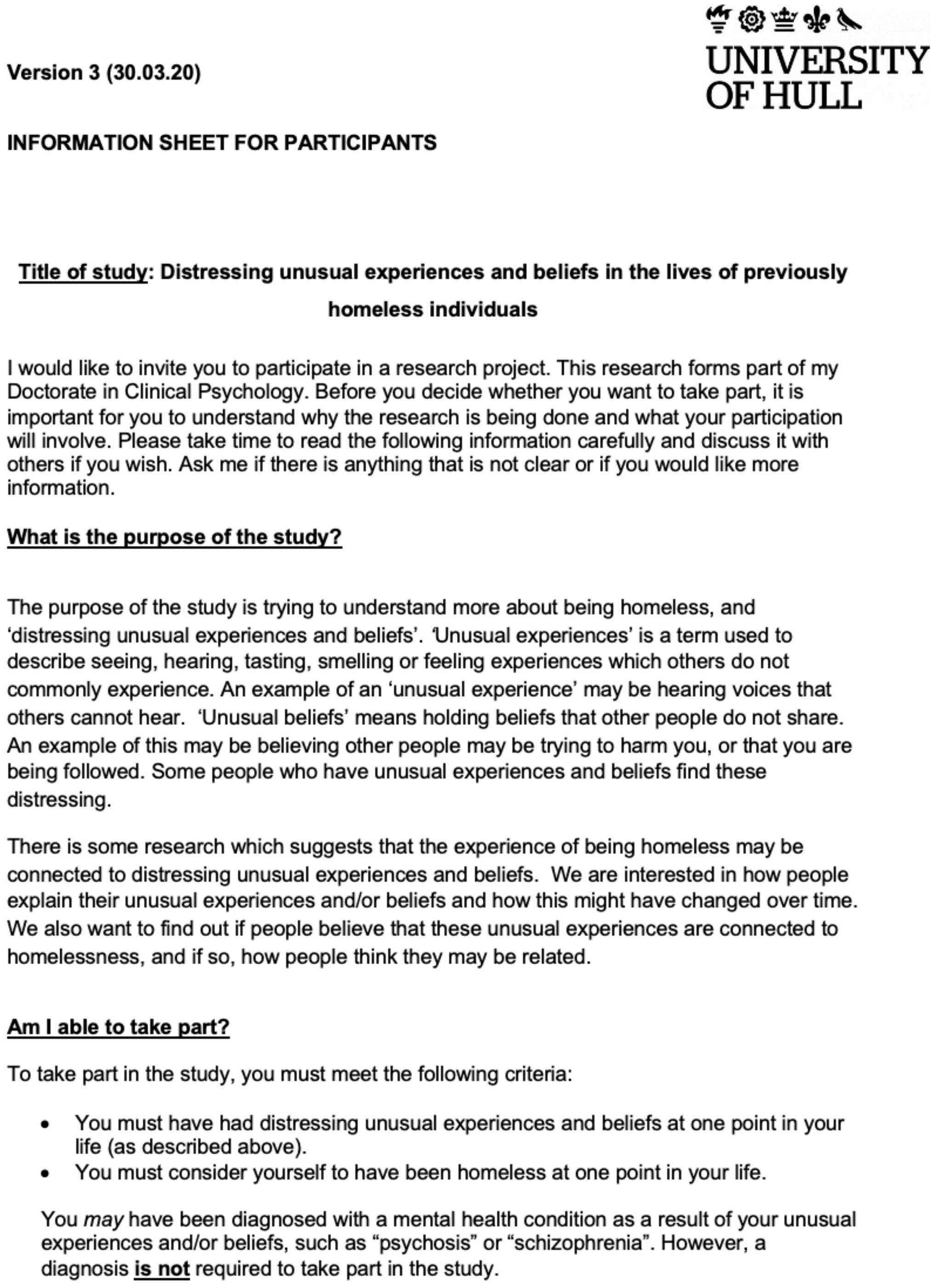
- You must have had "distressing unusual experiences and beliefs" at one point in your life (as described above).
- You must consider yourself to have been homeless at one point in your life.
- You *may* have been diagnosed with a mental health condition as a result of your unusual experiences and/or beliefs, such as "psychosis" or "schizophrenia". However, a diagnosis **is not** required to take part in the study.

PLEASE TAKE AN INFORMATION SHEET FOR ADDITIONAL INFORMATION!

TO REGISTER YOUR INTEREST PLEASE COMPLETE A 'CONSENT TO BE CONTACTED' FORM, OR CONTACT THE RESEARCHER (HANNAH GREENWOOD) DIRECTLY

EMAIL: H.E.GREENWOOD-2018@HULL.AC.UK

Appendix M: Participant Information Sheet
Note: the charity organisation name has been covered to further protect anonymity



Version 3 (30.03.20)

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INFORMATION SHEET FOR PARTICIPANTS

<u>Title of study</u>: Distressing unusual experiences and beliefs in the lives of previously homeless individuals

I would like to invite you to participate in a research project. This research forms part of my Doctorate in Clinical Psychology. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

<u>What is the purpose of the study?</u>

The purpose of the study is trying to understand more about being homeless, and 'distressing unusual experiences and beliefs'. 'Unusual experiences' is a term used to describe seeing, hearing, tasting, smelling or feeling experiences which others do not commonly experience. An example of an 'unusual experience' may be hearing voices that others cannot hear. 'Unusual beliefs' means holding beliefs that other people do not share. An example of this may be believing other people may be trying to harm you, or that you are being followed. Some people who have unusual experiences and beliefs find these distressing.

There is some research which suggests that the experience of being homeless may be connected to distressing unusual experiences and beliefs. We are interested in how people explain their unusual experiences and/or beliefs and how this might have changed over time. We also want to find out if people believe that these unusual experiences are connected to homelessness, and if so, how people think they may be related.

<u>Am I able to take part?</u>

To take part in the study, you must meet the following criteria:

- You must have had distressing unusual experiences and beliefs at one point in your life (as described above).
- You must consider yourself to have been homeless at one point in your life.

You *may* have been diagnosed with a mental health condition as a result of your unusual experiences and/or beliefs, such as "psychosis" or "schizophrenia". However, a diagnosis **<u>is not</u>** required to take part in the study.

What will happen if I take part?

If you choose to take part in the study, you will be asked to tell your story about your experience of homelessness and your unusual experiences and beliefs. You will be asked to speak freely, and you may give as much or as little detail as you wish. You can decide where you begin your story, and what you choose to include. When you have finished telling your story, you may be asked some follow-up questions.

Participation will take place in a private room at [redacted]or via a telephone call/'Zoom' video call if social distancing measures due to the COVID-19 pandemic still apply. The length of time it will take depends upon the time it takes to tell your story. However, an average estimation is from 30 minutes up to an hour. As part of participation you will be asked to provide your age, how long you were homeless for and how long you have been staying at [redacted] for. With your permission, the discussion will be audio recorded on a secure encrypted laptop.

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in any way. Once you have read the information sheet, please contact us if you have any questions that will help you make a decision about taking part. If you decide to take part, we will ask you to sign a consent form and you will be given a copy of the consent form to keep.

Payment

If you choose to take part in the study, you will receive a £10 Amazon voucher as compensation for your time.

What are the possible risks of taking part?

There is a chance that telling your story may involve discussing difficult periods in your life. However, what you choose to disclose is entirely up to you. Some people may find this upsetting. Following the interview, you will be given information on how to access further support services if required.

What are the possible benefits of taking part?

Some people find that telling their story has a positive effect on their emotions. Some people find the experience of contributing to research empowering and valuable.

Data handling and confidentiality

The information you give me will be processed in accordance with the General Data Protection Regulation 2016 (GDPR). The audio-recorded data from the study will be stored on a Humber NHS encrypted and password protected laptop. It will be backed up on secure encrypted and password protected servers at the University of Hull. A written transcript of the recording will be made, which will be anonymised using a pseudonym (alternative name). Your signed consent form will have your name on it, and will be stored in a locked storage cabinet at the University of Hull.

The researcher may be required to disclose information to other professionals if there is a risk of harm to yourself, or others. By law, the researcher is required to disclose any illegal activities relating to the actual or potential harm of children or vulnerable adults, UK anti-terrorism legislation, and/or money laundering. Substance use (e.g. Using drugs or alcohol) will be kept confidential, unless there is a risk of harm to yourself or someone else.

The information you give me will only be accessible by the researcher, and their two research supervisors (Dr Anjula Gupta and Dr Chris Sanderson). The information will not be shared outside of the EU or with any third party organisation.

The results of the study will be written up in a report, which will be published in academic journals. Your contribution to the study would remain anonymous. No identifiable or personal information will be included in the report. Direct quotes from participants may be used in the report. These will be anonymous and will not contain any identifiable or personal information.

The personal information you give me will be kept in the locked cabinet for 6 months after the completion of the study, and then destroyed. The anonymised written transcripts will be kept for 10 years on secure drives at the University of Hull.

Data Protection Statement

The data controller for this project will be the University of Hull. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under GDPR is a 'task in the public interest' You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you. Information about how the University of Hull processes your data can be found at https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/data-protection.aspx

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the University of Hull Information Compliance Manager [dataprotection@hull.ac.uk]. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

What if I change my mind about taking part?

You are free withdraw at any point of the study, without having to give a reason. Withdrawing from the study will not affect you in any way. You are able to withdraw your data from the study up until the point of data analysis (5 days after your discussion with the researcher). After this date, withdrawal of your data will no longer be possible due to the data being anonymised and analysed. If you choose to withdraw from the study, previous information you have provided will be withdrawn.

How is the project being funded?

This study is being funded by the University of Hull.

What will happen to the results of the study?

The results of the study will be summarised in a report. This will form part of the researcher's Doctoral Thesis as part of the Doctorate in Clinical Psychology. The results may also be shared via conference poster at research conferences. The results may be published in an academic journal. You will have the opportunity to receive a digital copy of the finished report if you wish. The results of the study will be shared with [redacted] and staff during a short presentation.

Who has reviewed this study?

Research studies are reviewed by an independent group of people called a Research Ethics Committee. This is to protect your interests. This study has been reviewed and authorised by the Faculty of Health Sciences Ethics Committee, University of Hull.

Who should I contact for further information?

If you have any questions, require more information about this study, or wish to register your interest in participating, please contact me using the following contact details:

Email: H.E.Greenwood-2018@hull.ac.uk

Phone (Text or Call): 07735148796

If I do not answer the telephone, please leave a message and I will get back to you.

Alternatively, you can complete a 'Consent to be Contacted' form with your details, and return it to a staff member whom will pass it on to myself. I will then contact you using the details you have provided.

What if I have further questions, or if something goes wrong?

If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the details below for further advice and information:

Dr Anjula Gupta

University of Hull
Faculty of Health Sciences
Aire Building Room 134
Hull, HU6 7RX, UK

Email: a.gupta@hull.ac.uk
Telephone: 01482 464087

Dr Chris Sanderson

University of Hull
Faculty of Health Sciences
Aire Building Room 134
Hull, HU6 7RX, UK

Email: c.sanderson@hull.ac.uk
Telephone: 01482 463378

Alternatively please contact registrar@hull.ac.uk

Thank you for reading this information sheet and for considering taking part in this research.

Appendix N: Consent to be Contacted Form

Version 3 (30.03.20)

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Research: Distressing unusual experiences and beliefs in the lives of previously homeless individuals

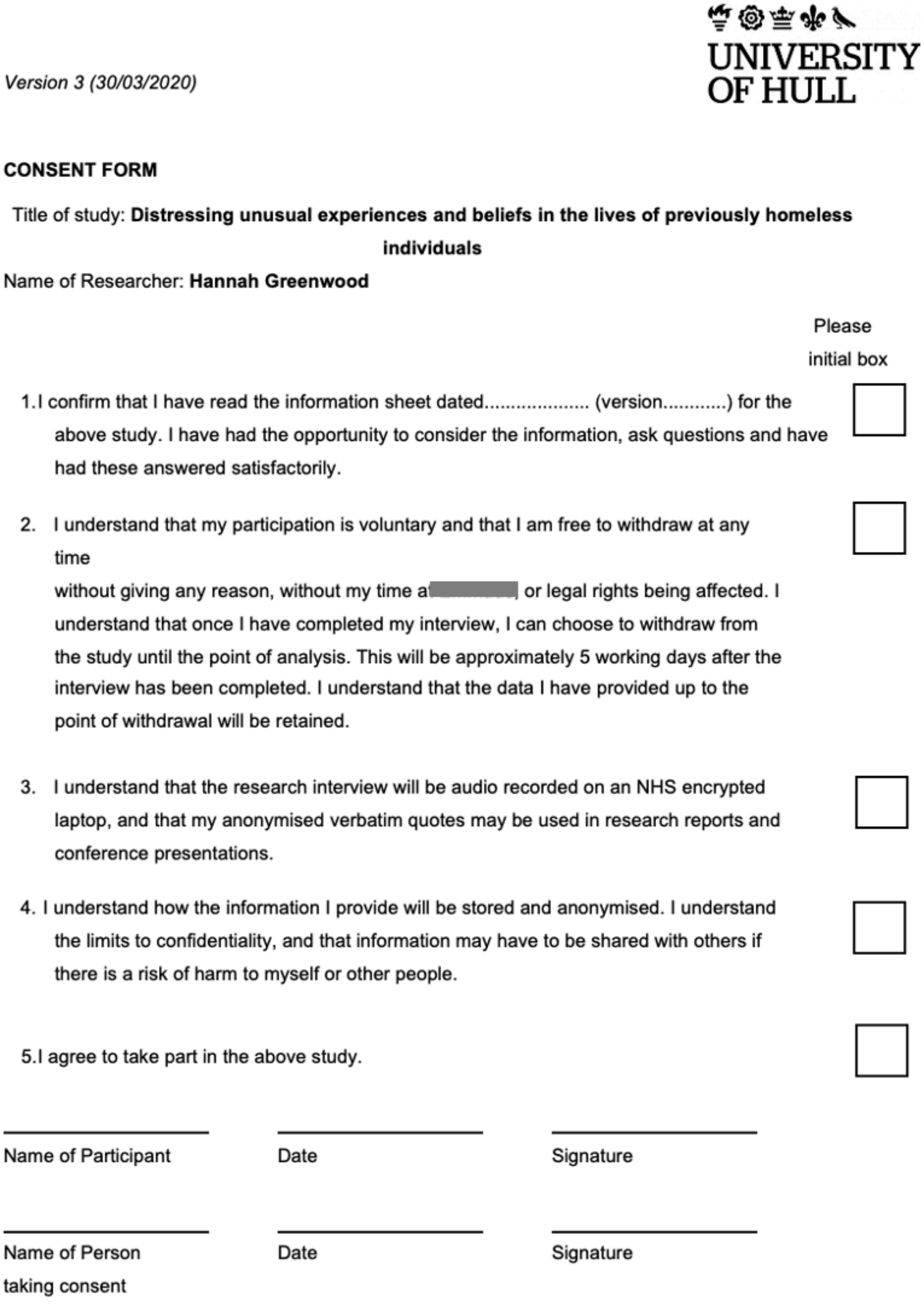
If you are interested to take part in the study, please leave your contact details on the space provided below. You will be contacted by the researcher to arrange a meeting at a convenient place and time.

Name:
....
Address:
....
....
....
....
Telephone Number:
....
Mobile Phone Number:
....
Are there any times of the day that you prefer to be contacted?
....
Do you have any further comments?
....
....

Signature:...
Date:...

Thank you very much for your interest!

Appendix O: Consent Form



Version 3 (30/03/2020)

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CONSENT FORM

Title of study: **Distressing unusual experiences and beliefs in the lives of previously homeless individuals**

Name of Researcher: **Hannah Greenwood**

Please initial box

1. I confirm that I have read the information sheet dated.................... (version............) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my time a[redacted], or legal rights being affected. I understand that once I have completed my interview, I can choose to withdraw from the study until the point of analysis. This will be approximately 5 working days after the interview has been completed. I understand that the data I have provided up to the point of withdrawal will be retained. ☐

3. I understand that the research interview will be audio recorded on an NHS encrypted laptop, and that my anonymised verbatim quotes may be used in research reports and conference presentations. ☐

4. I understand how the information I provide will be stored and anonymised. I understand the limits to confidentiality, and that information may have to be shared with others if there is a risk of harm to myself or other people. ☐

5. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix P: Sources of further support information sheet

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Version 1 (30.03.20)

Sources of further support

You can access further information and support from the following:

- Speaking to your allocated support worker at [redacted] They could also support you to access the following services:

NHS services

- **GP** – Your doctor (GP) is a useful place to start if you wish to access further support. They are able to refer you to other local services who may offer specific support for unusual experiences and/or beliefs.
- **NHS Direct –** You may wish to contact NHS Direct on 111.
- **NHS Website –** https://www.nhs.uk/oneyou/every-mind-matters/

Additional Services

- **Mind –** This organisation offers support directly through talking therapy and groups. They can also signpost you to various organisations in the local area that may be able to support you and your mental health. You can contact them on 01482 240200. **http://heymind.org.uk**
- **SANEline –** SANE is a charitable organisation that offers information and support for people struggling with their mental health. Telephone: 0300 304 7000. **www.sane.org.uk/home**
- **Samaritans –** The Samaritans are available around the clock and are able to talk to you, in a safe place, whenever you like and about whatever is getting to you. The number is FREE from any phone and you do not have to be feeling suicidal to call. You can contact the Samaritans on 116 123. **www.samaritans.org**
- **Rethink –** Rethink is a mental health charity which provides a wide range of support and signposting throughout the UK. They operate an advice line which can be reached on 0300 5000 927. For more information, please visit **www.rethink.org**
- If you require urgent support, and cannot wait to speak to your doctor, the Mental Health Response Team can be contacted on **01482 301701.**

Appendix Q: Example of analysed transcript

1. Well, I started when I was nine when I was nine years old and I got put into social care, by my mum because I was a bit of a handful. My mum couldn't cope with me so she had to protect the other kids by putting me in the care basically so....It's a bit of a...a... Hard one for her. But obviously I had ADHD when I was younger so I can... back then I don't understand why she did it, but now as I got older it sort of makes sense, so I got put there and then I started using drugs at age 9.

2. So the years I was in care and that wasn't the best years, [wasn't harmed in any way], but it would have been nice to be with my mum and dad, not not not with just random people, foster mums and that. But then I got used to a foster family through my teens and that. So I wasn't with my mum and dad till the age of 15.

3. And then I was developing drug habits through secondary school. And then I was withdrawing from drugs. [And I was trying to hide the...unhappiness of me.]

4. A fantasy home... [I was telling people I was from a rich family] blah blah blah and that but I wasn't, I was with my foster family. Even though my mum...my mum and dad weren't poor, but I didn't want to tell people at school...know that I was in a care home or a care baby, whatever you wanna call it.

5. And then they I developed a Coke addiction when I was 15

6. and then when I got put in detention at school, by a teacher and then he goes 'oh you're in detention you're in detention' and then I put him in hospital. I put a chair over his head. Yeah, and and [that's when my life turned around.]

7. Cos I got sent to prison for four years. Young offenders. And that sort of made me a bit more messed up.

Commented [HG1]: Holistic-Form: Turning Point 1: Going into Care

Commented [HG2]: IP1: A Handful

Commented [HG3]: Holistic Content/Theme 4: Harm - from others and to others

Emotional harm by being given up to the care system

Commented [HG4]: Holistic-Content/Theme 3: Unresolved Loss

Loss of security of biological family unit

Commented [HG5]: Holistic Content/Theme 6: The role and function of substances

Commented [HG6]: Holistic-Content/Theme 3: Unresolved Loss

Loss of family life

Commented [HG7]: Holistic Content/Theme 6: The role and function of substances

Commented [HG8]: IP2 – A Care Baby

Commented [HG9]: Holistic-Content/ Theme 1: Shame, Guilt and Hiding

Commented [HG10]: Holistic Content/Theme 6: The role and function of substances

Commented [HG11]: Holistic Content/Theme 4: Harm - from others and to others

Harm to others

Commented [HG12]: Turning Point 2 – assaulting a teacher.

8. And then, but maybe my ADHD didn't help me either... And when I was in there, the first three months of my sentence [I didn't do fuck all, I was rebelling against everyone.] Just wanted to get... just wanted to stand out. That's just me, I wanna be the loud one, I want to be the one to be attention seeking we'll call it.

Commented [HG13]: Holistic Content/Theme 4: Harm - from others and to others
Harm to others indicated?

Commented [HG14]: Holistic-Content/ Theme 2: Need for attention and approval

Commented [HG15]: IP 5 – Attention seeker

9. One day, my erm...someone pulled me aside... goes look you've got a choice... you can either do your A Levels and GCSE's while your in here, [when its for nowt, or sit on your boat for 3 years and get fuck all.]

Commented [HG16]: Holistic Content/Theme 5: Being cared for, and caring for others
Example of someone expressing care?

Commented [HG17]: Turning Point 4 – Conversation about gaining qualifications

10. So I got myself sorted, I got into it, got my NVQ in cheffing and got my A levels in PE – physical education – and then...but I didn't feel looked at? You know what I mean? I wanted to be the one that people go, yeah, look what he's doing well, you know what I mean, and yeah,

Commented [HG18]: Holistic-Content/ Theme 2: Need for attention and approval

11. but that's when the drugs came in aswell, the more and more drugs I took the more attention I got...you know what I mean? And that also led on to bad things as well.

Commented [HG19]: Holistic-Content/ Theme 2: Need for attention and approval

Commented [HG20]: IP 5 – Attention seeker

Commented [HG21]: Holistic Content/Theme 6: The role and function of substances

Drugs served the function of gaining attention from others
Drugs then played a role in other 'bad things' – criminality, homelessness etc

12. I realised that you do good things you get noticed, but you do bad things and you get noticed even more.

Commented [HG22]: Holistic-Content/ Theme 2: Need for attention and approval

Commented [HG23]: IP 5 – Attention seeker

13. It drove me to criminal burglary, burglaries were my...not my specialty but my...active...criminal activity.

14. And then, Yeah, anything I get anything for attention really I'll do it. If Someone said, oh, we can't do this well... basically trying to rebel with attention.

Commented [HG24]: IP 5 – Attention seeker

Commented [HG25]: Holistic-Content/ Theme 2: Need for attention and approval

15. I don't know if it's just something that I...I don't know, maybe...maybe I wanted attention from families I don't know what it was, but then it was... love from my mum and dad or anything 'cause they paid more attention to the other kids than me.

Commented [HG26]: Holistic-Content/ Theme 2: Need for attention and approval

Commented [HG27]: Holistic Content/Theme 4: Harm - from others and to others

Harmful early life experiences? Feeling unwanted/not paid attention too

16. And when it came to to the nitty and gritty, they couldn't handle a person with ADHD. Cos that was my diagnosis as a youngster.

17. And then when I got diagnosed with bipolar it started to make a bit more sense and that now. So it goes against everything.

18. So... when it just got to the point where I got outta jail and that and I was with my girlfriend as well, she liked the erm... She liked the bad boy in me and whatnot. And I was like ohhh I'm getting what I want now. Being the bad boy, bad boy, and whatever and that...it's getting me what I want. So I just kept to it. [More drugs I took the more trouble I got into more people noticed.] You know what I mean?

19. So it's just...The quiet life didn't give me what I want.. Any attention and that that is and that started when I got out of jail. I got outta jail when I was 19.

20. Got engaged with Mrs and then I cheated on my girlfriend. Got another girl pregnant. And that got me attention. See what I mean...so...

21. So the life stories that I hear about people doing...I've done...just to get attention. [We got told 'always stand out',] but the thing is in wrong way to stand out for the wrong reasons.

22. [So, but then I got more delusional] [interruption, someone walked in to the office]. [Delusional and that..].drug habit. So like anything, If I could stand out in anyway, I'll do it, good or bad. I had to be noticed. To fill my own insecurity. [And that's what carried on all my life.]

23. And then someone just sat me down and went 'Right, just because you're not being noticed for a good thing or bad, does not mean you're not being noticed. So you could try it this way. Do things, but don't expect... Don't disrespect it...respect things in life. But good and bad.'

24. And I was like... okay, so now it's just...just do what I gotta do. [No matter what anyone else thinks,] cos I do worry what other people think as well.

Commented [HG28]: Identity Positioning 1; A Handful

Commented [HG29]: Contradiction – Later says rejects bipolar diagnosis

Commented [HG30]: Identity Position 3 – The Bad Boy

Commented [HG31]: Holistic Content/Theme 6: The role and function of substances

Drugs kept up 'bad boy' image which got him 'seen' and noticed by others

Commented [HG32]: Holistic-Content/ Theme 2: Need for attention and approval

Commented [HG33]: IP 5 – Attention seeker

Commented [HG34]: Holistic-Content/ Theme 2: Need for attention and approval

Commented [HG35]: Turning Point 5 – cheating on girlfriend, needing attention and 'bad boy' identity

Commented [HG36]: Holistic Content/Theme 4: Harm from others and to others

Emotional harm to others

Commented [HG37]: IP 5 – Attention seeker

Commented [HG38]: Holistic-Content/ Theme 2: Need for attention and approval

Commented [HG39]: IP 5 – Attention seeker

Commented [HG40]: Holistic-Content/ Theme 2: Need for attention and approval

Commented [HG41]: IP 5 – Attention seeker

Commented [HG42]: IP 4 – Insecure person

Commented [HG43]: Insecurity - from childhood trauma and being put in the care system? 'too difficult to handle'? Identity Position?: Self as insecure

Commented [HG44]: Holistic-Content/ Theme 2: Need for attention and approval

Commented [HG45]: Holistic Content/Theme 5: Being cared for, and caring for others

Commented [HG46]: Turning Point 6 – Conversation about how to be noticed differently

25. Uh-huh I'm very good scenario running in my head of situations, like they haven't even happened yet. But when it comes to like...say I'll do a job...in any sort of way like er, so I'll do a job. And people look at me, and I'm thinking they're thinking 'ah you've done a shit job blah blah blah' but even though I'm doing a good job.

26. It's just this..... , but then I'm also ummm..ummm withdrawing from drugs as well.

27. Drugs and mental health do not go. 'Cause you don't know whether it's withdrawal or actual symptoms.

28. Uh, when they when they diagnosed me with bipolar in jail, 16 years ago, I was actually going through a uhhhh...uhh.. heroin opiate detox. So I don't know if they got me on..just thought I'm bipolar. You know what I mean, so it's harder than that. So I just..get to that really.

29. But my biggest problem in life is my insecurity. Thinking that I've gotta please everyone or I don't please them you know what I mean.

30. So when I was on the street...it's just mad. It brought out the more....more errr...loneliness in me. [I needed to be around people.] I've gotta be around people, if im not around people im just...im just worse.

31. So..thats pretty much what I mean, my biggest problem is my insecurity. And paranoid. Worrying what people will think and stuff like that. And that's what I just do, I just keep working working working not just to make people like me or anything like that, just to feel secure about myself. Does that make some sense?

Researcher: Yeah, that makes complete sense...

Martin: It's a weird one It's a very weird one.

Researcher: That makes complete sense and I think thank you for sharing all that with me..how do you think erm kind of...did you mention that you've sort of heard voices and things as well as sort of...(Martin nodded)...could you tell me a bit about how that came about?

32. **Martin:** When I was...I think I was 17 my erm my real mum passed away. That's when my erm real mum actually passed away when I was only 17.

Commented [HG47]: Holistic Content/Theme 6: The role and function of substances

Drugs complicate the picture with mental health

Commented [HG48]: IP6 – A person with Bipolar

Questioning Bipolar Identity

Commented [HG49]: Holistic Content/Theme 6: The role and function of substances

Drug withdrawal may have led to a diagnosis of Bipolar, didn't take into account wider context

Commented [HG50]: IP 4 – Insecure person

Use of the word 'my insecurity' rather than 'feeling insecure'– indicated views it as a central component of his identity as an insecure person

Commented [HG51]: Seems to be unsure if bipolar diagnosis accurately captured what was going on for him at that time, and reframes it as 'insecurity' underlying everything, influenced by drug withdrawal

Commented [HG52]: Holistic Content/Theme 4: Insecurity, People pleasing

Commented [HG53]: IP 4 – Insecure person

Commented [HG54]: Holistic-Content/ Theme 2: Insecurity and the need for attention and approval

Commented [HG55]: IP 4 – Insecure person
Influence of identity as an insecure person related to action - working

Commented [HG56]: I was aware of this from the initial phone call made to see if Martin was eligible for the research

Commented [HG57]: Co constructed the narrative – influence of my question prompted the next part of the story.
Martin didn't include voices in his initial narrative.

Commented [HG58]: Holistic-Content/Theme 3: Unresolved Loss

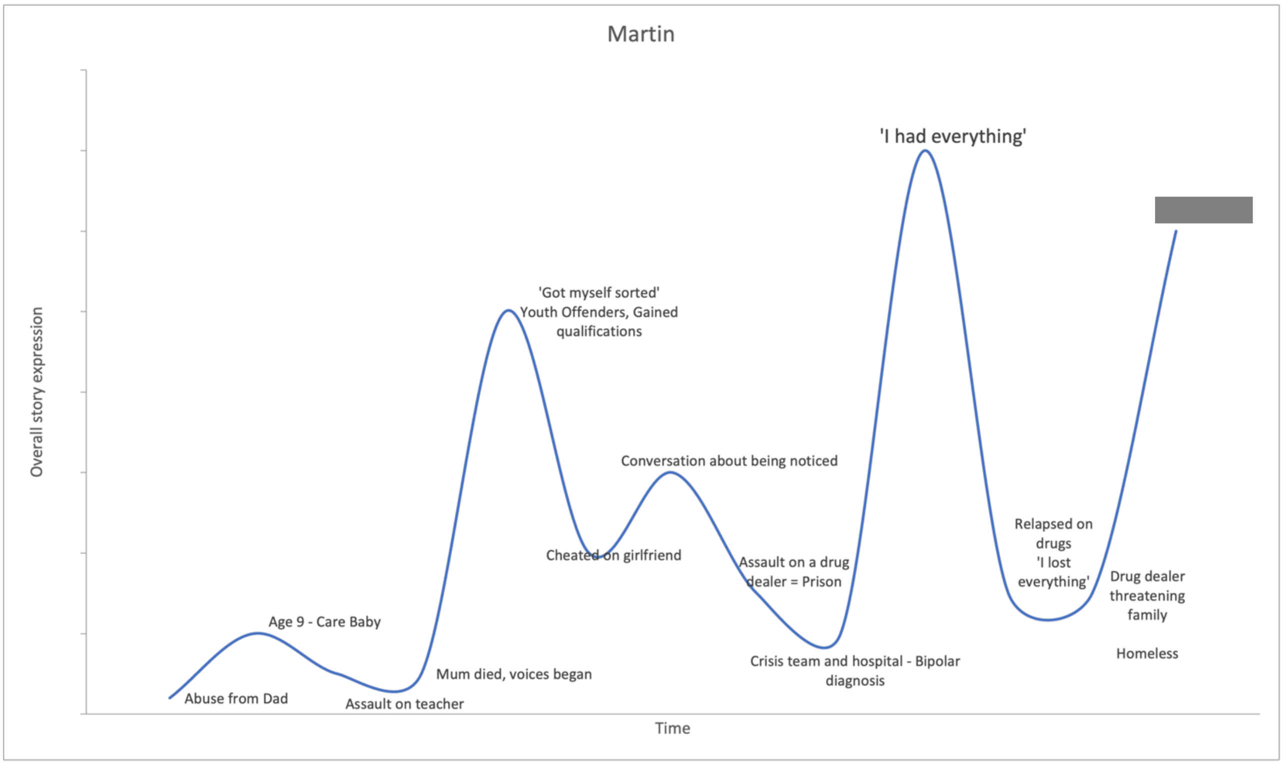
Commented [HG59]: Turning Point 3: Loss of Mum, voices began

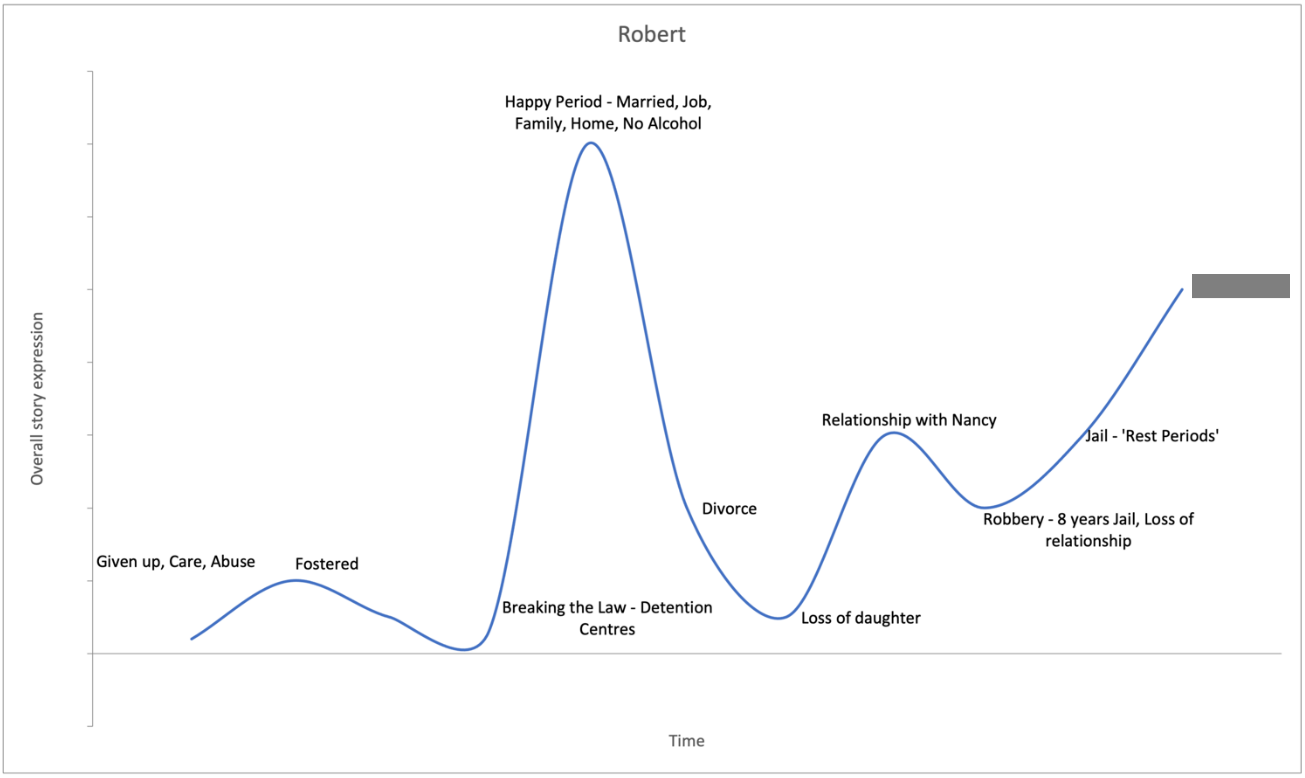
Appendix R: Key themes which emerged from the Holistic-Content Analysis for individual stories.

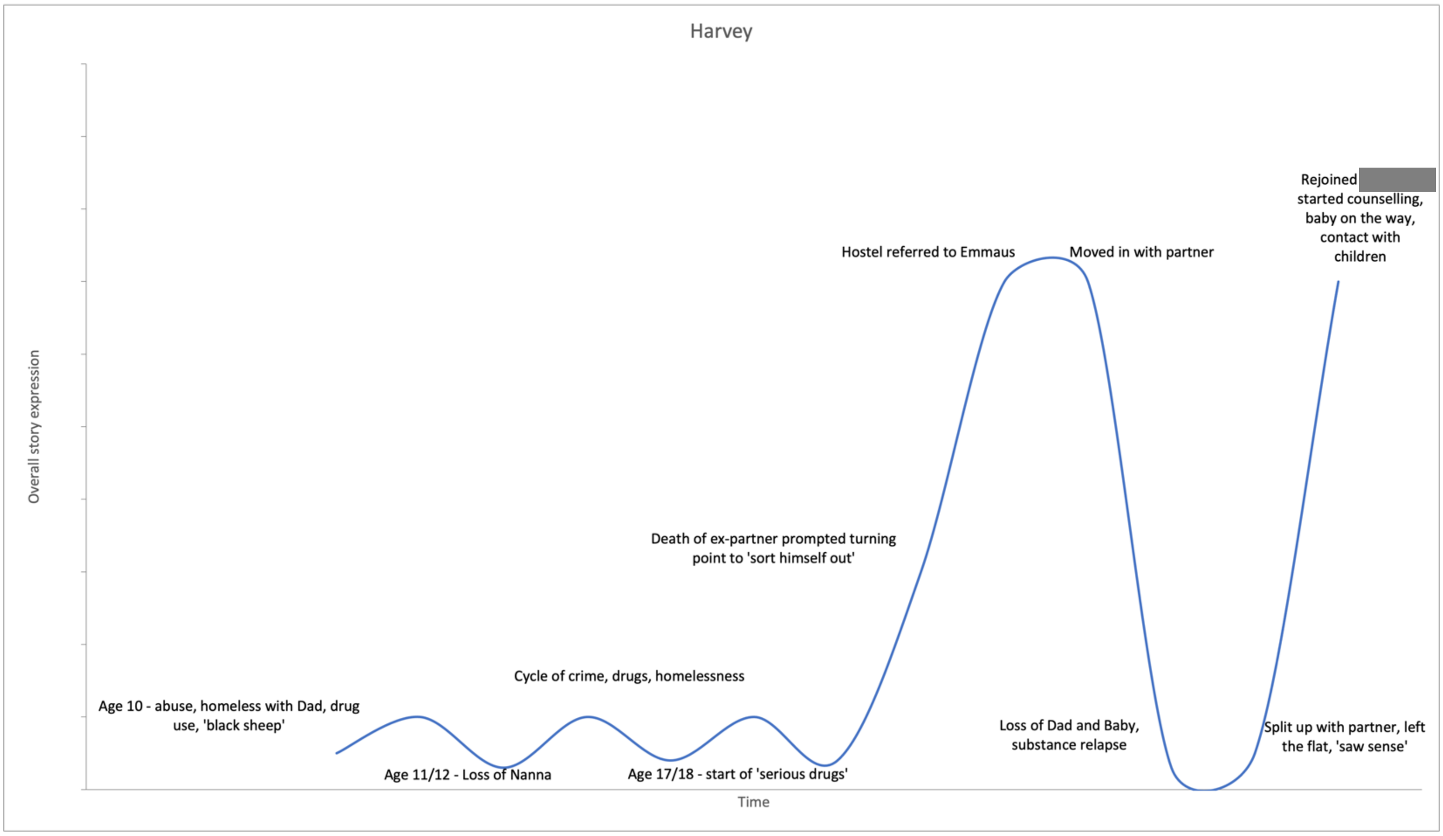
Participants	Key Themes
Martin	1: Shame and Guilt
	2: Being hidden and overlooked
	3: Passivity vs Agency
	4: Insecurity and the need to be seen
	5: Unresolved Loss
	6: Harm - from others and to others.
	7: The role and function of substances
Robert	1: Religious sense making: A Guiding Hand
	2: Being alone vs. being around others
	3: Role of substances (drugs, alcohol)
	4: Being let down by others
	5: Loss
	6: Self-Preservation
	7 : Agency, autonomy and power
Steve	1: Role and Function of Substances (illegal and prescribed)
	2: Unintentional Sporadicity of Life
	3: Power and Control
	4: Spiritual and Religious Experiences and sense-making
	5: Burnout and neglecting the body's physical needs
Harvey	1: Trauma and Loss
	2: Role and function of substances
	3: The value and importance of talking
	4: Paranormal and Spiritual Sense Making
	5: The importance of non-judgement
	6: A sense of agency
James	1: Up and Down
	2: Safety and Security
	3: The importance of 'having a laugh'
	4: Being on edge

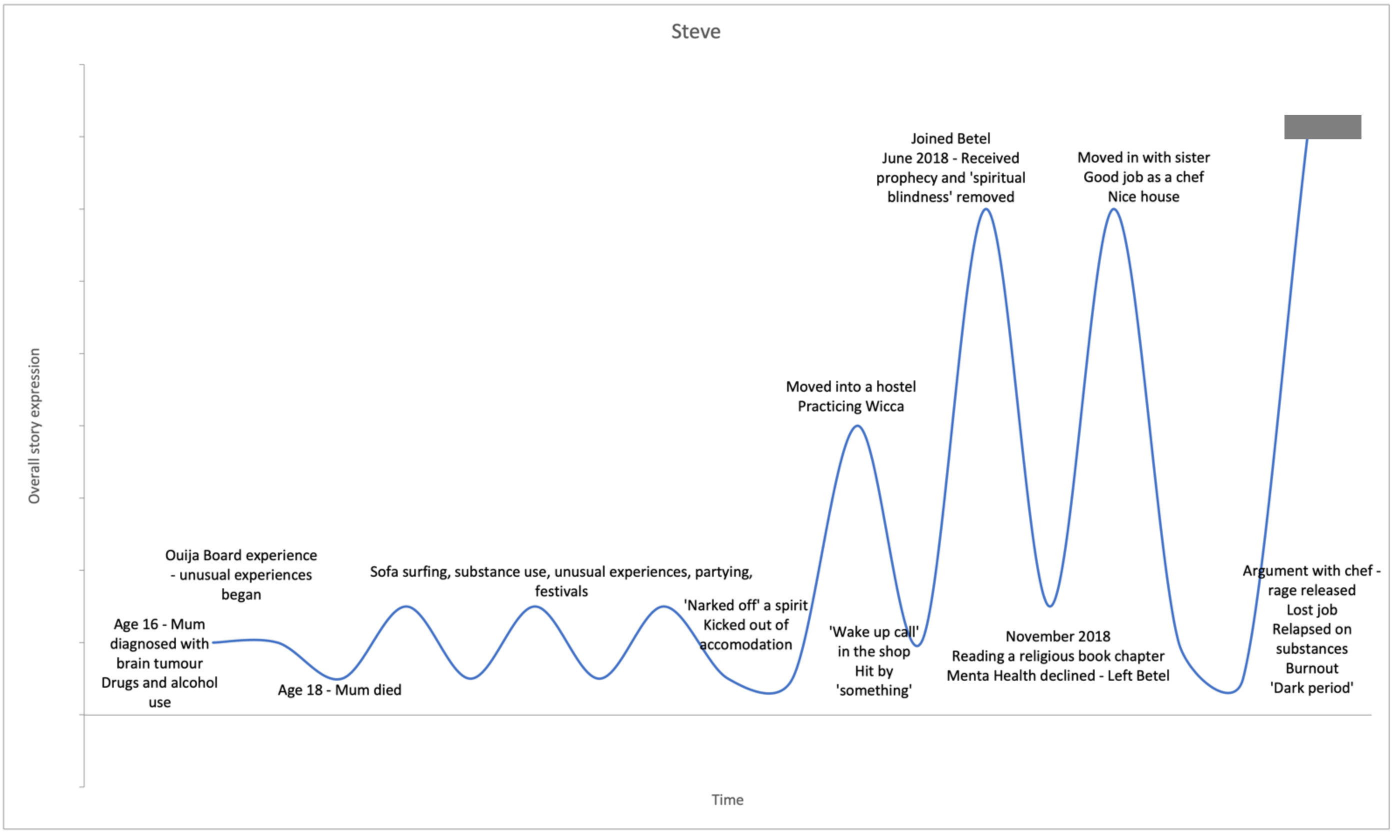
	5: Agency and Choice
	6: Not fitting in vs. fitting in
Andrew	1: Safety: Am I gonna be alright?
	2: Role and function of substances
	3: Trying to fit in with others
	4: Fear of judgement
	5: The impact of unsuitable and inconsistent accommodation

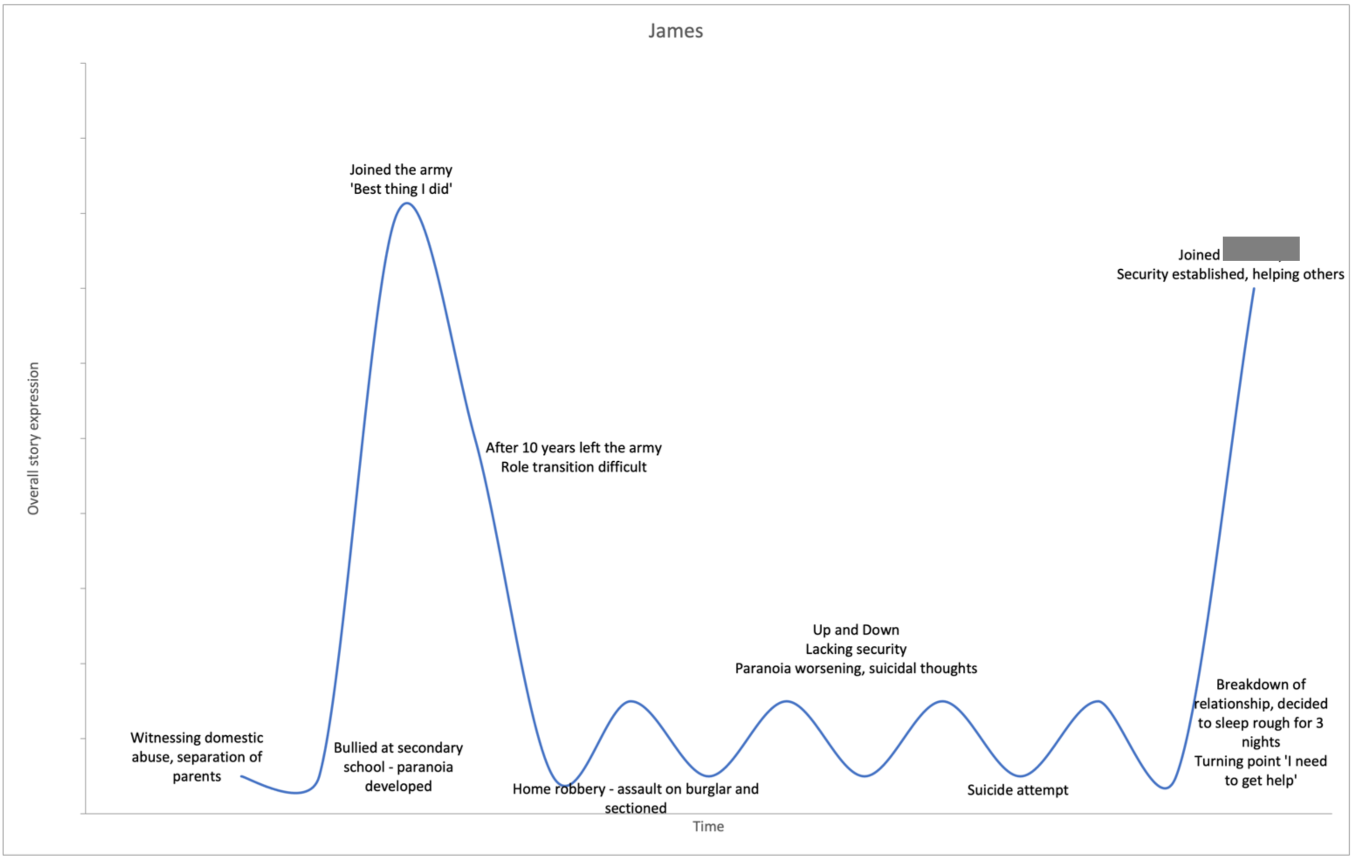
Appendix S: Individual Plot Graphs

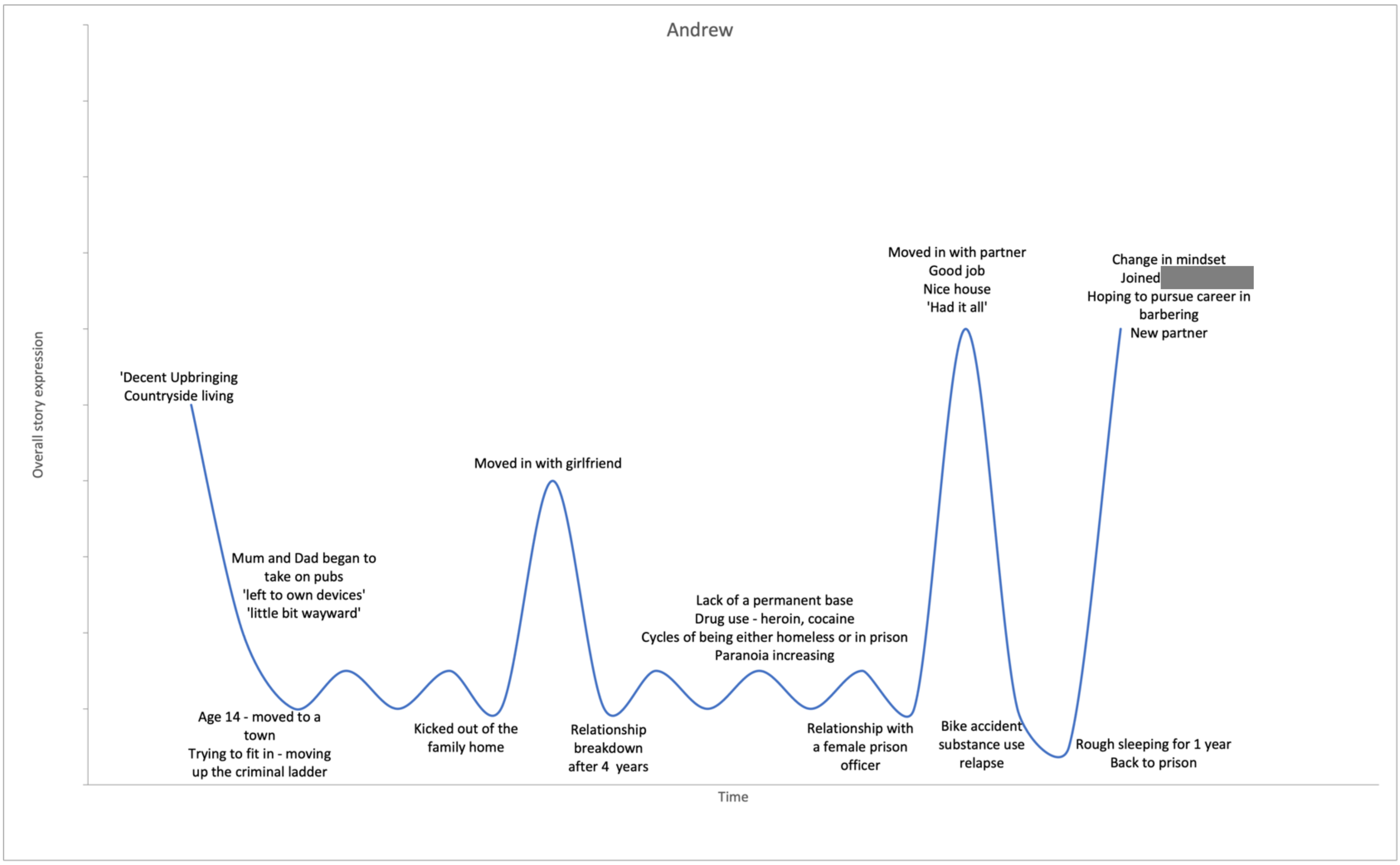





Harvey
Overall story expression
Time
Age 10 - abuse, homeless with Dad, drug use, 'black sheep'
Age 11/12 - Loss of Nanna
Cycle of crime, drugs, homelessness
Age 17/18 - start of 'serious drugs'
Death of ex-partner prompted turning point to 'sort himself out'
Hostel referred to Emmaus
Moved in with partner
Loss of Dad and Baby, substance relapse
Split up with partner, left the flat, 'saw sense'
Rejoined [redacted] started counselling, baby on the way, contact with children


Steve
Overall story expression
Time
Age 16 - Mum diagnosed with brain tumour Drugs and alcohol use
Ouija Board experience - unusual experiences began
Age 18 - Mum died
Sofa surfing, substance use, unusual experiences, partying, festivals
'Narked off' a spirit Kicked out of accomodation
Moved into a hostel Practicing Wicca
'Wake up call' in the shop Hit by 'something'
Joined Betel June 2018 - Received prophecy and 'spiritual blindness' removed
November 2018 Reading a religious book chapter Menta Health declined - Left Betel
Moved in with sister Good job as a chef Nice house
Argument with chef - rage released Lost job Relapsed on substances Burnout 'Dark period'
[redacted]


James
Overall story expression
Time
Witnessing domestic abuse, separation of parents
Bullied at secondary school - paranoia developed
Joined the army
'Best thing I did'
After 10 years left the army
Role transition difficult
Home robbery - assault on burglar and sectioned
Up and Down
Lacking security
Paranoia worsening, suicidal thoughts
Suicide attempt
Breakdown of relationship, decided to sleep rough for 3 nights
Turning point 'I need to get help'
Joined [redacted]
Security established, helping others


Andrew
Overall story expression
Time
'Decent Upbringing
Countryside living
Mum and Dad began to take on pubs
'left to own devices'
'little bit wayward'
Age 14 - moved to a town
Trying to fit in - moving up the criminal ladder
Kicked out of the family home
Moved in with girlfriend
Relationship breakdown after 4 years
Lack of a permanent base
Drug use - heroin, cocaine
Cycles of being either homeless or in prison
Paranoia increasing
Relationship with a female prison officer
Moved in with partner
Good job
Nice house
'Had it all'
Bike accident substance use relapse
Rough sleeping for 1 year
Back to prison
Change in mindset
Joined [redacted]
Hoping to pursue career in barbering
New partner

Appendix T: Language used to describe DUBE within participants stories

Participant	Words used to describe DUBE
Martin	Voices, paranoia, blackouts, blank moments, delusional thoughts, a revenge voice, ‘my mum in my head’, ‘my mum’s voice’, a grieving voice, little phases, ‘the moments’, daydream vision, paranoid beliefs
Robert	Seeing things, a guiding hand, Planet Zoltoff, hearing voices, visions, little flashbacks, little voice in my head, muffled stuff, white noise, my voices, a guide
Steve	Mystical thoughts, unusual experiences, hallucinations, figures, a little girl, the spirit, the spirit realm, the darker side of spirituality, something guiding/protecting me, experience with the spirit realm, spirits and demons around me, voice in my head, something, out of body experience, black figure, seeing things
Harvey	Seeing things, paranoid, believing I was being followed, thinking people were hiding in bushes, feeling like somebody is watching me
James	Paranoia, ‘thinking people are watching me, looking at me, talking about me’, thinking someone’s in an empty house with me, feeling paranoid/really anxious, being on edge, a breakdown, a spell, PTSD
Andrew	Paranoia, paranoid, thinking people are talking about you, anxiety, head exploding, spiralling out of control, my head wandering about

Appendix U: Additional supporting quotes

Theme/subtheme	Quotes
Holistic-Content: Trauma and abuse	*"…at the age of 7 my parents split up […] my father was quite abusive to my mum, err used to hit her and stuff…" (James)* *"If I really sit and admit to it, that's one of the main reasons why I've been in and out of jail and off and on drugs because of what happened when I was a kid" (Harvey)* *"I was left to my own devices, so I started going a little bit wayward." (Andrew)*
Holistic-Content: Unresolved Loss	*"Well, my mum was diagnosed with a brain tumour when I was about 16. And obviously it progressed rapidly. And as this sort of happened, this is when I really began started using drugs and alcohol, specifically alcohol cause obviously the stress of it all was... It was just ridiculous"(Steve)* *"And then when my little girl passed away, my first girl [name] when she passed away of meningitis, my mum would be in my head going 'you killed your daughter. You killed your daughter..." (Martin)* *"…getting a happy period of my life when I married and got a nice little family, a decent job and everything, then losing that and then back down the bad path again[…]it's the loss of my daughter what slipped me again…" (Robert)*
Holistic-Content: Judgemental attitudes	*"…It's a very tough life and people...people get judged just for fucking...wearing…scruffy clothes, they think they're scum bags, they think they're no good, but deep down could be a fucking really nice person and deserve the bit of help" (Harvey)* *"And then that's when your anxiety will probably kick in, you're gonna be paranoid about going out, leaving your flat. Because, I do it, I've been very judgmental [...] you think why have you come all the way over here from [Yorkshire city name]. Are you hiding from somebody, you know." (Andrew)*
Holistic-Content: Fitting in: isolation vs connection	*"...put me by myself...no...I'm not worth anything, I'm not. I just give up everything. Give up all hope when I'm by myself." (Robert)* *"I felt lost, there was no one around me for me to get any sort of […] Attention… there you go… attention again. There's no one to erm notice me to do whatever. No one to talk to" (Martin)*
Holistic-Content: Relational Coping	*"I love to have a laugh, I love having a joke, and I do with a lot of them in here, bit of a prankster, nothing bad. I just like to make people laugh and stuff like that, I don't have to put much effort into it, cause I think its just natural, the way I am. […]yeah that does help, that does help me, massively." (James)* *"And I like it cos everybody respects me in here, they know what I'm like, they do, its err it's what I need." (Robert)*

Holistic-Content: Physical wellbeing	*"And obviously now I know it was just through neglecting my body, I wasn't eating a lot, I was doing a lot of hours. I was just burnt out, you know. And I think it is important to recognise like the difference between natural burnout and what comes from burnout. Like hallucinations, hearing things, seeing things." (Steve)* *"Its fucking horrible being out there. Especially if you haven't got no blankets or nowt and you're sleeping in doorways every night, you just wanna die. You just don't wanna do it anymore. And you can't see a way out."(Harvey)*
Holistic-Content: Psychological well-being	*"I was out yesterday and I was getting a bit anxious, just being in town. And I was only popping to two shops, but I did it as quick as I could, because I was getting really anxious, for no reason at all." (James)* "*And when I'm sat down, I have to have my back against the wall. That's the thing I have to do. I just can't sit with someone walking behind me and stuff like that, I just can't do it. It just puts me on edge." (James)* *"Erm, so basically I finished the army, I can never forget, I finished on a Friday, they let me out 6 months early cause I was offered a contract with an MOD contractor to work with them straight away, so basically I was a civilian after a weekend. Well, making the transition was hard, I found it so hard to work with civilians and that at the time…" (James)* *"I know we all talk to ourselves in our heads when we're doing jobs and whatever and stuff like that. But mine, can be like, saying I'm worthless and stuff like that. And that's when the suicidal thoughts start coming on, saying you're better off just killing yourself." (James)* *"I just couldn't really see an end, and it was like, fucking...what have I got to lose really? I've got nothing. I always kept wishing that I could get a job and get a family, but that was down to me in the end […] But you..your mental health just goes bad 'cause you just don't give a fuck."* *(Harvey)*
Holistic-Content: Substance use	**Function:** *"but that's when the drugs came in aswell, the more and more drugs I took the more attention I got...you know what I mean?"* *(Martin)* *"And then I was developing drug habits through secondary school. And then I was withdrawing from drugs. And I was trying to hide the...unhappiness of me."* *(Martin)* **Impact:**

	"The day that the erm drug dealer went around there with a shotgun, put shotgun to my kids head and my erm ex-wife's head, telling me I had 15 minutes to pay the money up. That sort of...sealed the bullet for me in a way." *(Martin)* *"And when I stopped taking drugs, my paranoia was getting…not getting bad…but staying at some sort of level. I was still thinking the same things." (Martin)* *"...I moved into a flat I had and it...my flat was a right bloody state, you can imagine as a young kid, you know what I mean. One day I woke up and my flat looked pristine to me, I couldn't see the filth in front of me, it was like I was in a brand new place, I don't know where that came from, that that that feeling of the place being smart and tidy went on for a full day, but I put that down to using hallucinate drugs."* *(Robert)* *"If there's one thing I can't do, I cannot drink, I can't do drugs. I might as well just fucking sign my death warrant. […] One thing leads to another… everything has a knock on effect. […] but if I have a drink, I guarantee at the end of the night I'll be on drugs. If I do drugs, I know it'll lead on to my homelessness...it'll affect where I'm living. Cos you get selfish. You don't care." (Martin)* *"Cos while you're on the streets, it's not gonna happen...all your appointments and that...it's a waste of time cos you're not gonna go to them. Especially if you're rattling one night...one day... rather than go to the appointment...you're not gonna go to the appointment rattlin'…." (Harvey)*
Holistic-Content: Spiritual, Religious and Paranormal sense making	*"…I feel like there's summit following me, and it's getting worse at the moment, it's more like when I'm in the dark […] Like there's somebody staring at me […] its quite freaky. Especially on your own. […] I'm a massive believe in life after death. I'll record my film and there's loads of orbs flying about in me room, loads and loads man. And when other people come in me room, they say they can ..it feels different in my room." (Harvey)* *"It strengthens my belief that, there is more out there and there is more stuff going on around us like in other dimensions. And I think I've just I've just been born with the gift of being able to see that, hear it, adapt it, and mould it to my own liking" (Steve)* *"Like when my mum passed away and I was like sofa surfing and I was moving from A to B, I'd still see, I'd see all these different type things and hear, erm like it seemed to like get worse after my mum passed away." (Steve_* *"I have very strong periods of empathy. Where, I can be around someone and I can pick up on their pain. […] So I I have to be very careful about who I touch, who I'm sat with for a long period of time, because I can literally pick up on their mood […] and It's very difficult to get rid of. Luckily now, I know, I have the skills like through*

	meditation to be able to just repeat my mantra and then it brings me back down to earth and it helps me repel their..any energy.. you know?" (Steve)
Holistic-Content: Safety, Security and Stability	*"...I never had that security. I had a good job, a really good job and that, and friends as well, I worked with a lot of guys who were ex-military, but it just...I never had that security. My confidence started going again and stuff like that." (James)* *"Obviously I wasn't per se homeless, but when you're in a homeless shelter you don't…you don't feel settled , it don't feel like your home d'ya know what I mean […] I'm a guest here, you know". (Steve)* *"I believe if I was in like a stable situation, in my own house, Keeping a job down… then possibly the drugs wouldn't have been such an issue…" (Steve)* *"Cos I've got no certain plan at the moment have I, my life is full of uncertainties, I just don't know what's around the bend, I cannot actually plan, I'm here, I'm happy at the moment but I can't say this is permanent, I can't" (Robert)*
Holistic-Form: A difficult start	*"I've tried to block a lot of my past out cos I went through quite a few bad experiences when I was...growing up" (Robert)*
Holistic-Form: Up and down cycles	*"Erm, but yeah, so and then I came out of there thinking that I was okay and stuff, and then about another 6 months, back down...I just gone up and down constantly all the time" (James)*
Holistic-Form: Having it all	*"I mean, I had everything. I had everything. I had a really nice house in the middle of nowhere, no neighbours, no nothing. With a partner, I had a car, I had a really good job to go back to. But, my mindset was 'What's the point?'." (Andrew)*
Holistic-Form: Losing it all	*"And that's when it's very dangerous for me, cause once I hit that point of self-destruct, that's when everything else had like a domino effect. You start off losing one thing, and then before you know it, you're at the end of the track and you've lost absolutely everything. And that's, that's where I was." (Andrew)*
Holistic-Form: Achieving stability	*"Cause I've got a good gig going on now, you know, I've got a lot of stuff coming here, from [charity accommodation name] […] Um, and like I say, Um, my mental health has improved massively since I come here. I haven't had no periods of psychosis while I've been here." (Steve)* *I've got nowt to worry about, I'm in a good place. I mean I'm quite happy at the moment so...no need to rush anything, I'll do it in my time when I'm ready." (Harvey)*
Holistic-Form: An uncertain but hopeful future	*"And I just like to be able to put my hand to things and just learn new things and train myself in different ways. And that's why I love [charity accommodation name] cos it gives you the opportunity to do that in so many different ways. You know, so yeah I'm really happy with the decision to come here, and it is like miracles for me." (Steve)* *"To be honest with ya, I don't want anything fancy. I just want a basic life and I've got that here […] It's not complicated. And when l get into complicated situations. That's where things start going….erm…wrong." (Martin)*

	"I wanna use all these experiences and everything that I believe and see, even the stuff that I'm not really sure on, but utilise it and grow on it and harness it to get to where I want to be in the future, which is counselling, specialist, drug and alcohol work. So yeah, I'm just keeping my eyes on the prize, really. And, as I say, not letting the drudgery and the sham of the world get to me." (Steve
Critical Narrative Analysis: Childhood Identity Positions *A child who was 'bad' and could not be managed*	*"…and when I wouldn't settle down when I was being a little shit person, my mum would actually give me my sisters diazepam to get me to go to sleep, which is obviously highly illegal. But it was the only way my mum could get me to settle down, cause I would just refuse to go to sleep." (Steve)*
Critical Narrative Analysis: Childhood Identity Positions *A child unwanted and uncared for*	*"My mum and dad started taking on pubs and stuff. And I was just left to my own devices." (Andrew)* *"…just thinking well If my mam don't care, why should I?" (Harvey)*
Critical Narrative Analysis: Childhood Identity Positions *Vulnerable and helpless*	*"I think as a child I was quite shy as a kid, I got bullied quite bad, especially in secondary school. Erm, never stood up for myself, erm and that" (Andrew)* *"I'm past caring about where my journey takes me anymore really. I want it to be in a nice place like this, I do, but at the end of the day, if it goes the other way, it doesn't bother me, it doesn't, I'll survive, like I always have done" (Robert)*
Critical Narrative Analysis: Adulthood Identity Positions *Self as flawed*	*"I'm not worth anything I'm not I just give up everything. "(Robert)* *"I was rebelling against everyone. Just wanted to get... just wanted to stand out. That's just me, I wanna be the loud one, I want to be the one to be attention seeking we'll call it." (Martin)* *"But my biggest problem in life is my insecurity."* *"My insecurity…fucking…up the roof […] my paranoia and insecurity...yeah. That's probably another reason why I turned to drugs"* *(Martin)*
Critical Narrative Analysis: Adulthood Identity Positions *A person with an illness*	*"Obviously I've never been told I'm paranoid schizophrenic cos I know wholeheartedly I'm not, but I have been told in the past that I could possibly have bipolar, but in the end I got diagnosed with borderline personality disorder."* *" I've been put on different medications at the, many times, so I've used Quetiapine, which I'm still taking low dose of Quetiapine now, but they've tried me on Olanzapine, on Sertraline, Sodium Valproate, Err, Diazepam, lorazepam…" (Steve)*

	And that's when the psychiatrist went...you've got bipolar...manic depression...whatever it's called...and stuff like that. And I was like oh great thank you. Bearing in mind that I'm also withdrawing from heroin as well. Thank you." (Martin)
Critical Narrative Analysis: Adulthood Identity Positions *Self as unusual*	*"...you know I'm not I'm not God, I'm not Jesus but I've just just got unusual gifts." (Steve)* *" It feels like I'm on like another realm to other people almost [...] I'll still have periods where I think Am I on another plane to everyone else? You know it feels like I'm looking in through a window."(Steve)*
Critical Narrative Analysis: Emerging Identity Positions *A person with positive qualities valued by others*	*"I mean, they've always told me from when I first started cutting hair, probably 7, 8 years ago. They've always said you've got natural talent to do it, so go with it." (Andrew)* *"From the moment I've come in here, I wanted to do a bit of everything and luckily I have and and much more like I've done acts of solidarity, like out of the community, and it's not gone unnoticed, you know [...] I'm currently doing my Level 3 food safety and hygiene, [...] Bearing in mind like a year and half ago, I wouldn't even dream about doing any education or training, I just wanted to get a hit." (Steve)* *"Even though I've only been here 5 weeks, but they said you've fit in so well with everyone. They've said your demeanour, the way you are at work, you work so hard, and just get on with it. But its...you have that time for the others as well which we really like. The atmosphere in the place is a lot better, and it is, it is." (James)*
Critical Narrative Analysis: Emerging Identity Positions *A person who cares for others*	*"My caring side since being with [charity accommodation name] has just got...I didn't even realise I had. I didn't really think my caring or looking out for people was there. Cos I used to be the person to get people to look out for me." (Martin)* *"I'm like the father figure again...cos I like caring about other people more than myself." (Robert)*
Critical Narrative Analysis: Emerging Identity Positions *A person who has agency, control and choice*	*"I'll set myself challenges every day, the staff are helping me. I'm coping with all this mental health thing, talking with you, me workshop, new companion I've had to deal with, all little challenges each day for me." (Robert)* *"I've learnt now that its only myself than can make my future what I want it to be. I can't... do anything else, yeah you can get the help as much as you need, from mental health and stuff like that, obviously I've been through it all before. It's you that can do it, you can't just have people there wiping your arse and stuff, which it's true. You've gotta really put the effort in" (James)*