Copyright Statement

The digital copy of this thesis is protected by the Copyright Act 1994 (New Zealand).

This thesis may be consulted by you, provided you comply with the provisions of the Act and the following conditions of use:

- Any use you make of these documents or images must be for research or private study purposes only, and you may not make them available to any other person.
- Authors control the copyright of their thesis. You will recognize the author's right to be identified as the author of this thesis, and due acknowledgement will be made to the author where appropriate.
- You will obtain the author's permission before publishing any material from their thesis.

General copyright and disclaimer

In addition to the above conditions, authors give their consent for the digital copy of their work to be used subject to the conditions specified on the Library Thesis Consent Form and Deposit Licence.
How I Got Here: Personal Narratives of Youth Mental Health Difficulties and Recovery

Rebecca Herald

A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Clinical Psychology,
The University of Auckland, Aotearoa New Zealand, 2018.
ABSTRACT

New Zealand is currently facing high rates of youth mental health difficulties and suicide. While there is growing recognition that young people can offer useful insight into their own experiences, there is a paucity of research exploring youth perspectives on what is known as “recovery” from serious mental health problems. This study sought to address this research gap by conducting narrative style interviews with 12 young people who self-identified as having once experienced mental health difficulties, but now being some way along the recovery process.

The interview data was analysed using both narrative and thematic methods. The narrative analysis identified five different types of narratives participants used to describe their experiences. This variation was largely based on different causal explanations that young people utilised to account for their difficulties. These explanations appeared to shape their subsequent recovery and also had significant implications for their sense of self. The thematic analysis identified themes relating to the way participants described the role of professional support in their recovery. While young people described it being difficult to engage with mental health services overall, they also found positive relationships and specific interventions helpful. Both analyses highlighted participants’ emphasis on self-responsibility and agency, yet described significant limitations on their ability to successfully exert this.

Overall, these findings emphasised the personal, active nature of recovery. While many of the recovery processes and concepts identified in adult literature are relevant to youth recovery, young people also face unique challenges. These related to young people’s relative dependence on both familial and formal systems of care, limitations on their agency and emphasis on identity development during this period of life. These findings suggest that health professionals should attempt to work together in partnership with the young people that they are supporting, to create an individualised approach to their care. They should also be aware of the significant impact these experiences can have on a young person’s identity. Significant changes to the mental health system may be required to enable clinicians to work in this personalised, recovery focused way.
ACKNOWLEDGEMENTS

To the young people who offered their time and trusted me with your stories–thank you. Without you, this thesis would not exist. I hope I have done your stories justice and that this research can make a least a small contribution towards changing things for the better–a hope I know motivated a number of you to participate. A big thank you to all the people from the peer and consumer community who offered advice and wisdom, and the organisations who provided the practical support that helped turn my initial idea into this piece of work.

A huge thank you to my supervisor, Kerry Gibson. Your support, encouragement and guidance over the past few years has been invaluable and so, so appreciated. I am also so grateful for the critical, questioning stance you helped weave into our clinical training, and your optimism in the potential for positive change. Also to Fraser Cross, for helping me survive internship year with constant kindness and an amazingly calm demeanour.

Thanks to Mum, Dad and Chloe, for supporting me through this long, long journey, despite everything else that life has thrown your way. Simon–thank you for your endless supply of love, patience and interpretive dance. Mum and Si, a special thanks to both of you for taking the time to proof read this. Ricky, thank you for keeping me company while I typed away over the last few months, and for being forgiving about the less than optimal number of walks.

To my other friends and family, thanks for putting up with my increasingly long periods of absence. I am looking forward to having a bit more time to spend time with you again. To my classmates, the only people who really understand what the last five years have involved–thank you for everything! Finally, to the team at Hapai Ora and especially Jonathan, your support and flexibility has gone so far beyond what I would have ever expected. I am incredibly grateful to be working in a service that is genuinely focused on supporting young people and their families in a holistic and recovery-focused way.
# TABLE OF CONTENTS

ABSTRACT......................................................................................................................................................... i
ACKNOWLEDGEMENTS........................................................................................................................................... ii
TABLE OF CONTENTS........................................................................................................................................... iii
LIST OF TABLES .................................................................................................................................................. v
GLOSSARY .............................................................................................................................................................. vi
Chapter One: Introduction to the Study .................................................................................................................. 1
Chapter Two: Literature Review ............................................................................................................................. 5
  Youth Mental Health ........................................................................................................................................... 5
  Youth Mental Health Services in New Zealand ................................................................................................. 22
  Recovery Paradigm .............................................................................................................................................. 29
  Youth Perspectives on Mental Health Difficulties, Recovery and Service Use ............................................... 42
  The Current Study in Context ........................................................................................................................... 54
Chapter Three: Methodology ................................................................................................................................. 56
  Theoretical Framework ....................................................................................................................................... 57
  Approach to youth research ............................................................................................................................... 63
  Method ................................................................................................................................................................. 67
  Summary ............................................................................................................................................................... 81
Chapter Four: Narrative Analysis Recovery, a Personal Journey .......................................................................... 82
  The “Sensitive Self” Narrative ................................................................................................................................ 82
  The “Bad Choices” Narrative ............................................................................................................................. 92
  The “Not Me, the Situation” Narrative ............................................................................................................ 100
  The “Surviving the Chaos” Narrative ............................................................................................................. 107
  The “Product of the System” Narrative ........................................................................................................ 116
  Summary ............................................................................................................................................................ 123
Chapter Five: Thematic Analysis the Role of Professional Support in Recovery ................................................. 125
  Struggling with Services ...................................................................................................................................... 125
  The Human Relationship ................................................................................................................................. 132
  The Impact of Interventions ............................................................................................................................. 138
  Personal Agency and Engagement .................................................................................................................... 146
  Helping Others: Working on the Other Side .................................................................................................... 153
  Summary ............................................................................................................................................................ 157
Chapter Six: Discussion and Conclusions ............................................................................................................ 158
  Narrative Analysis: Stories of Recovery ........................................................................................................ 158
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thematic Analysis: The Role of Professional Support in Recovery</td>
<td>165</td>
</tr>
<tr>
<td>Implications</td>
<td>172</td>
</tr>
<tr>
<td>Future Research</td>
<td>176</td>
</tr>
<tr>
<td>Strengths and Limitations of the Study</td>
<td>177</td>
</tr>
<tr>
<td>Concluding Comments</td>
<td>180</td>
</tr>
<tr>
<td>Appendices</td>
<td>182</td>
</tr>
<tr>
<td>Appendix A: Participant Information Sheet—Organisational Representative</td>
<td>182</td>
</tr>
<tr>
<td>Appendix B: Participant Information Sheet</td>
<td>185</td>
</tr>
<tr>
<td>Appendix C: Consent Form—Organisational Representative</td>
<td>188</td>
</tr>
<tr>
<td>Appendix D: Consent Form—Participant</td>
<td>190</td>
</tr>
<tr>
<td>Appendix E: Interview Guide</td>
<td>192</td>
</tr>
<tr>
<td>Appendix F: Transcriber Confidentiality Agreement</td>
<td>194</td>
</tr>
<tr>
<td>Reference List</td>
<td>195</td>
</tr>
</tbody>
</table>
LIST OF TABLES

Table 1: Participant Demographic Characteristics ........................................71
GLOSSARY

The following terms and abbreviations specific to the New Zealand context have been used throughout this report:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Service.</td>
</tr>
<tr>
<td>CYF</td>
<td>Child, Youth and Family—the previous name of the New Zealand child welfare agency. During the completion of this research, this agency was renamed Oranga Tamariki–Ministry of Children.</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Board—in New Zealand, both physical and mental health services are delivered through regional governmental organisations (DHBs) that cater to the needs of people living in a specific geographical area.</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner.</td>
</tr>
</tbody>
</table>
Chapter One: Introduction to the Study

The mental health of young people in New Zealand has been of considerable public interest over the past decade (Elliott, 2017; Gattey, 2017; Hendry, 2018). More broadly, a “crisis” in mental health has recently been acknowledged by policy makers in New Zealand, leading to a Governmental Inquiry into mental health and addiction in this country (Mental Health and Addiction Inquiry, 2018). Research suggests that New Zealand’s rate of youth mental health difficulties is slightly higher than international prevalence rates of 20–25% (Fergusson & Horwood, 2001; Oakley Browne, Wells, Scott, & Mcgee, 2006; Patel, Flisher, Hetrick, & McGorry, 2007). New Zealand also has one of the highest rates of youth suicide in the OECD (Ministry of Social Development, 2016) and youth mental health services in this country are under intense pressure (Allan, 2018; Elliott, 2017). There are differing opinions regarding the factors driving this “crisis of youth mental health”; however, it has been suggested that the specific social conditions of our time have led to young people in contemporary New Zealand (and other Western societies) to face particular stressors that may increase their susceptibility to mental health problems (Bor, Dean, Najman, & Hayatbakhsh, 2014; Furling & Cartmel, 2007; Gluckman, 2017; Wyn & Andres, 2011).

Over the last 20 years, the concept of recovery, or living well following an experience of mental health difficulties, has become increasingly influential (Ahmed, Buckley, & Mabe, 2012; Tew et al., 2012). This concept grew out of the “service-user” and “lived experience” movement that privileges knowledge gained through personal experience over clinical or professional knowledge (Chamberlin, 1978; Mead & Copeland, 2000). Since the 1990s, the concept of recovery has influenced the development of mental health services in New Zealand (Ahmed et al., 2012; Mental Health Commission, 1998, 2012; Ministry of Health, 2006, 2012, 2018).
While many have cited the movement towards a recovery paradigm as positive, there are a number of issues when considering youth mental health specifically. Firstly, recovery has largely grown out of adult perspectives and there has been limited exploration regarding what recovery looks like, or means for young people (Honey, Coniglio, & Hancock, 2015; Ward, 2014; Ward, 2015). Secondly, mental health services in New Zealand that are supposed to support individuals with their recovery process, are fragmented and poorly funded (Allan, 2018; Elliott, 2017). Both these services, and the concept of recovery itself, are also shaped by the prevailing discourses of individualism, self-management and biomedicalisation (Rapping, 1996; Read, 2005; Rimke, 2000; White & Wyn, 2013). These dominant ideas, while not inherently “bad”, profoundly shape the way people of all ages experience the process of recovering from mental health difficulties, and have been suggested to pose particular challenges for young people (France & Threadgold, 2016; France, 2007).

In spite of these constraints on the system, research suggests that young people who experience mental health difficulties are active participants in their recovery process (Barnett & Lapsley, 2006; J. E. Leavey, 2009; Rayner, Thielking, & Lough, 2018). The existing literature on youth experiences of mental health difficulties and service use indicates that young people have some unique priorities and concerns compared to adults (Dunne, Thompson, & Leitch, 2000; Gibson & Cartwright, 2013; Gulliver, Griffiths, & Christensen, 2010). Thus, in order to more effectively support young people through the recovery process, and make appropriate recommendations for changes to the mental health system, we need to listen to what young people have to say. It is only by talking to young people that we can understand more about how they experience mental health difficulties and the recovery process, and gain insight into how young people engage with the services that are designed to support and facilitate the recovery process.
The recovery concept has largely been developed out of first-person narratives of mental health difficulties, and more broadly speaking, qualitative research paradigms (Kirkpatrick, 2008; Rhodes & De Jager, 2014; Spector-Mersel & Knaifel, 2017). The present study applies this approach by eliciting youth accounts of mental health difficulties and recovery through narrative interviews. The participants in this study all self-identified as experiencing mental health difficulties that began before or around the age of eighteen, and were under the age of 30 at the time of the interview. Overall, these young people described their difficulties as causing significant and extended disruption to their lives. In order to gain insight into how they conceptualised the process of recovery from their difficulties, to be included in the study people had to consider themselves to be some way along the recovery process. Finding a way to access such a group of people posed some initial recruitment challenges. Young members of New Zealand’s mental health peer workforce were identified as potentially offering a particular, yet important range of perspectives. Although not directly focusing on the professional role of peer support and consumer advisors, the present research aims to provide a space for their voices to be heard and the value of their lived expertise to be acknowledged.

While a narrative approach underpinned this research overall, the personal accounts elicited through the interview process were analysed using both narrative and thematic methodologies. Utilising these two analytic methods allowed me to identify and consider patterns of meaning both within and across the narrative forms. This approach allowed for the exploration of unique experiences and personal meaning-making processes to be interpreted in the context of broader structures and discourses that define mental health and recovery. This analytic process, and the project more generally, has of course been influenced by myself as the researcher. In particular, it is important to highlight that this study was undertaken to fulfil part of the requirements of my clinical psychology training at
the University of Auckland. It was also completed in parallel with working in mental health services in Auckland, New Zealand, most recently in an early intervention psychosis service that accepted young people up to the age of 30. My professional interest in youth mental health, as well as my own personal experiences of mental health difficulties as a young person, influenced my decision to pursue this particular topic.

The following chapter provides a literature review that aims to situate this study in both the existing body of relevant research and its wider social context. Chapter Three outlines the methodology that guided this research, including epistemological and theoretical underpinnings, as well as the specific analytical methods used. Chapter Four and Chapter Five present the findings of the narrative analysis and thematic analysis respectively. Finally, Chapter Six provides an overall review of the findings, situating them in the existing literature and identifying the unique contribution of this study. Practical implications of the findings are discussed, strengths and limitations of the study identified and suggestions for future research are made.
Chapter Two: Literature Review

This chapter aims to situate the present research in both its broader social context and the existing body of related literature. Firstly, a rationale for examining youth mental health will be outlined, with a particular, but not exclusive focus on New Zealand. Secondly, I will identify the definition of “youth” that guides this research, and locate the research in its social context. This will include discussion of dominant discourses such as individualisation that have grown out of a neo-liberal environment and influence the way many contemporary Western societies think about mental health problems. This will be followed by a description of the “recovery” paradigm, its current implementation in New Zealand and the services designed to facilitate and support personal recovery in this country. Mental health services will also be situated in their contemporary, socio-economic context. This will include a discussion of the dominant discourses surrounding mental health service provision and recovery. Attention will then be paid to the current service user literature, with a specific emphasis on youth perspectives on mental health difficulties, service experiences and recovery more generally. Finally, I will outline the aims of the present study and specific research questions that were developed.

Youth Mental Health

Public discourse in contemporary New Zealand asserts that the country is currently facing a “youth mental health crisis” (Elliott, 2017; Gattey, 2017; Hendry, 2018). It has been estimated that approximately one third of young people in New Zealand experience a mental health issue during a 12-month period (Oakley Browne et al., 2006). Authors of a longitudinal study conducted in New Zealand suggested prevalence rates of one in four young people at the age of 15, increasing to four in ten at the age of 18 (Fergusson &
Horwood, 2001). These figures are slightly higher than international prevalence rates which are estimated to sit between 20–25% (Patel et al., 2007). A recent report from the New Zealand Government’s Chief Science Advisor has suggested that youth mental health difficulties are increasing (Gluckman, 2017). However, as no national prevalence studies have been published since 2006, this has yet to be substantiated (Allan, 2018). International figures indicate that the rates of young people being diagnosed with mental disorders are increasing (American College Health Association, 2008; Collishaw, Maughan, Goodman & Pickles, 2004; Rutter & Smith, 1995; West & Sweeting, 2003). Numerous reasons have been cited for this upward trend including increased public and professional awareness, expanding diagnostic categories and an actual increase in underlying rates of disorders and psychological distress in youth populations (Bastra & Frances, 2012; Bor, et al., 2014; Francis & Nardo, 2013; Maughan, Iervolino, & Collishaw, 2005).

Existing New Zealand research does indicate that mood disorders, substance abuse and self-harm are the most common mental health issues young people cite as experiencing (Mental Health Commission, 2011). Internationally, rates of comorbidity in clinically referred samples of youth are extremely high, with many young people included in these samples having multiple diagnoses at one time (Angold, Costello, & Erkanli, 1999). Coexisting mental health difficulties and substance use problems are also common in New Zealand: Non-age specific New Zealand statistics that indicate that over 50% of people using mental health services are thought to have co-existing substance use problems, and over 70% of those using addictions services having co-existing mental health conditions (Todd, 2010). International statistics suggest that among clinical samples of young people with alcohol dependence, approximately 89% have a co-occurring psychiatric diagnosis (Clark et al., 1997).
A large body of evidence suggests that mental health disorders are a significant risk factor for suicide (Beautrais, Joyce, & Mulder, 1996; Brent, Baugher, Bridge, Chen, & Chiappetta, 1999; Grøholt, Ekeberg, Wichstrøm, & Haldorsen, 1998; Shaffer et al., 1996). In New Zealand, suicide is far more common in people who use mental health services than those who do not (Ministry of Health, 2010). Recent alarming statistics indicate that New Zealand has the highest youth (15–24 years) suicide rate out of all 34 OECD counties (Ministry of Social Development, 2016). In 2013, the youth suicide rate in New Zealand was 18.0 deaths per 100,000. Within this, twice as many young men committed suicide as young women, and Māori youth suicides occurred at more than twice the rate of non-Māori (Ministry of Social Development, 2016). While overall youth suicide in non-Māori youth has trended downwards since the mid-1990s, there has been no such trend observed for Māori young people (Ministry of Social Development, 2016). Suicide is also currently the leading cause of death among young (12–18 year old) Pacific people (Allan, 2018) and a recent New Zealand study identified that Pacific high school students were more than three times more likely to have made a suicide attempt than non-Pacific students (Clark et al., 2013).

Although youth suicide is a commonly discussed issue in contemporary New Zealand, it has not always been the case that high suicide rates have been associated with young people in this country: prior to the mid-1980s, the age groups with highest suicide rates in New Zealand were 45–64 and 65 years and over. However, between 1982 and 1992, the suicide rate for youth (15–25 years) increased from 10.8 deaths per 100,000 to 23.3 per 100,000 (Ministry of Social Development, 2016), while rates for the older groups of New Zealanders steadily declined. Non-fatal deliberate self-harm is also common among young New Zealanders, with a recent study indicating that just over 20% of New Zealand school students had engaged in self-harm (Wilson et al., 2014).
Much of the research into youth mental health has focused on the impact such issues can have on an individual’s long-term psycho-social development and socio-economic outcomes (Kessler, Foster, Saunders & Stang, 1995; Knapp, McCrone, Fombonne, Beecham & Wostear, 2002; Patel, Flisher, Hetrick & McGorry, 2007). Such research has suggested that longer-term effects may be a result of interrupted education subsequently leading to poorer (or different) vocational outcomes, or symptoms and medication side effect symptoms decreasing motivation and the ability to maintain a job. However other less tangible factors, such as stigma and discrimination, have also been cited as likely contributors to the longer-term impact of youth mental health issues. Research indicates that mental health issues carry the burden of enormous stigma (Corrigan et al., 2005; Lund et al., 2011). Stigma has been described as visible or invisible attributes that mark a person as different or belonging to a deviant subgroup, which ultimately lead to them being devalued and discriminated against (Hinshaw, 2005; Major, Kozlowski, Chao, & Gardner, 1995). While research examining mental health related stigma in young people is currently limited (Hinshaw, 2005), there is evidence to suggest that a significant proportion of young people with mental health issues experience stigma in their family, peer group and educational environments (Moses, 2010b).

Self-stigma is conceptualised as the internalisation of stigmatising discourses that exist in a society. Corrigan and Watson (2002) propose a three-part model of self-stigma in relation to mental health disorders: First the person applies negative “mental illness” labels to themselves then they endorse these labels and agree that they are crazy or incompetent (for example); and finally, they internalise the rejection they feel from society and start to disengage from opportunities as they do not feel worthy (Corrigan & Watson, 2002). Researchers have suggested that internalising stigmatising views related to mental health difficulties may be particularly harmful for young people due to their developing sense of self (Hinshaw, 2005).
Although currently limited, existing research indicates that a significant proportion of young people with a mental health difficulty report experiencing self-stigma (Kranke, Floersch, Kranke, & Munson, 2011). Kranke and colleagues (2011) interviewed 27 young people with mental health issues and identified that 24 of them held stigmatising views about themselves. The authors developed a model of youth self-stigma that involved linking their personal experiences to stereotypes of mental illness, feeling as though engaging in psychiatric treatment made them different from their peers, and attempting to protect their social reputation by hiding that they had a mental health issue (Kranke et al., 2011). However, not all people experience self-stigma in the context of mental health issues and there is evidence to suggest that some young people find a sense of belonging and positive identity from a diagnosis (Kranke, Jackson, Taylor, Landguth, & Floersch, 2013; Moses, 2010a).

However, the stigma associated with mental health issues is thought to create barriers to treatment engagement, as well as occupational, social and general community engagement. Both international and New Zealand research indicates that fear of stigma and discrimination can act as a barrier to young people talking about mental health problems or seeking help (Barnett & Lapsley, 2006; Fox & Butler, 2007). Researchers have suggested that conforming to peer group norms is of primary concern to young people (Raviv, Sills, Raviv & Wilansky, 2000), therefore making them more susceptible to the negative impact of stigma. Recently developed “one stop shops”, where young people can access multiple health and mental health services in one place, have been praised for helping to address the fear of stigma being a barrier for seeking help for mental health issues (Mental Health Commission, 2011). This type of service may also improve early intervention by identifying problems that young people are not fully aware of, or issues they think will just get better on their own.

Much psychological and psychiatric research into youth mental health is premised on the idea that the rate and scope of biological, psychological and social changes that occur
during the transition from childhood to adulthood make young people particularly vulnerable to mental health issues (Kaltiala-Heino, Marttunen, Rantanen, & Rimpelä, 2003; Mendle, Harden, Brooks-Gunn, & Graber, 2012; Smith, Chein, & Steinberg, 2013). However, it is being increasingly acknowledged that rapid social change and some aspects of contemporary society may also be negatively impacting the mental health of young people (Gluckman, 2017). In a discussion paper released by New Zealand’s Chief Science Advisor Peter Gluckman in 2017, the author positioned the “changing context” of young lives as extremely relevant to youth mental health and suicide rates in New Zealand. Gluckman points to changes in family structure and child rearing practises, decline of traditional social supports, rapid technological changes, increased choices at an early age, and increased pressure to succeed in the context of financial and social uncertainty, as placing unique demands on young people living in contemporary New Zealand society (Gluckman, 2017). These issues will be among those discussed in the following section that aims to contextualise youth mental health problems in New Zealand.

Overall, considering the high, and possibly increasing, number of young people with mental health issues in New Zealand, and associated suicide statistics, there are clearly important questions that need to be answered regarding how young people in this country experience having a mental health problem.

**Contextualising youth mental health issues.**

Conventional wisdom asserts that the period between childhood and adulthood is of key developmental importance. While in public discourse, the terms youth and adolescence are used somewhat interchangeably, they have originated from, and are associated with, very different theoretical standpoints (Gillies, 2000; Rattansi & Phoenix, 2005). Historically, dominant psychological perspectives have described “adolescence” as a discrete period of
time characterised by individual physiological, cognitive and emotional development, during which children “transition” to adulthood (Blakemore, Burnett, & Dahl, 2010; Gillies, 2000; Holmbeck et al., 2000). In contrast, “youth” is conceptualised more in terms of shared collective experiences, growing out of sociological traditions that emphasise the constructed nature of developmental stages (Hopkins, 2010; Mizen, 2004). The following section will outline these two definitions and clarify the theoretical approach guiding the present research. I will then locate youth in the current social context, focusing on social processes such as neo-liberalism and individualisation that have been posited as contributing to the rise in youth difficulties observed in New Zealand and many other modern Western societies.

Defining youth.

American psychologist Granville Stanley Hall’s 1904 work Adolescence is considered to mark the beginning of the scientific study of adolescence (Rattansi & Phoenix, 2005; Steinberg & Lerner, 2004). From this point forward, psychological theories of adolescent development have largely focused on the biologically driven physiological and psychological changes that characterise the process of young people maturing into adults (Gillies, 2000; Holmbeck et al., 2000). The start of adolescence is often considered to be demarcated by the onset of puberty and subsequently characterised by periods of rapid growth, changes to body shape and facial features, metabolic changes and sexual maturation (Blakemore et al., 2010). More recently, specific patterns of cognitive development have also been described as a key feature of adolescence and have been the focus of significant research attention since the mid-20th century (Keating, Lerner, & Steinberg, 2004).

In addition to these physiological changes, western psychological perspectives also propose that to successfully navigate the period of adolescence and transition to adulthood, a number of key psycho-social developmental tasks must be achieved. The development and consolidation of a personal identity is positioned as perhaps the most central of these tasks,
an idea heavily influenced by the work of developmental psychologist and psychoanalyst Erik Erikson (1968, 1963). Erikson’s theory of psycho-social stages (1963) outlines eight “tasks” that require resolution at different “stages” of life. The task Erikson proposes normative for “mid adolescence” is *identity versus role confusion* (1963), with role confusion referring to an inability to commit to identity-defining decisions or obligations. Erikson proposes that the struggle to experience continuity between how one views the self with how one feels they are perceived by others, as well to form a sense of “wholeness” characterises the normative identity crisis that occurs during this time (1968). From this perspective, identity is conceptualised as a unitary self-concept that once attained, remains relatively stable over time (Rattansi & Phoenix, 2005; Vignoles, Schwartz, & Luyckx, 2011). While Erikson (1963, 68) does refer to the influence of social expectations on this process (i.e. expectation to take on specific adult responsibilities), it is still very much positioned as a process of individual development.

A related key developmental task commonly associated with adolescence is increasing independence—that is, shifting away from the family of origin towards living as life an “independent” adult, before perhaps embarking on a serious romantic relationship and starting a family of one’s own (Goldscheider & Goldscheider, 1999; Hogan & Astone, 1986). Traditionally, it has been posited that “normally” developing young people will start seeking out romantic relationships, finalise their education and begin working life towards the end of adolescence. At this point, it is expected individuals will shift into “adult” roles—getting married, starting a family and cementing and progressing their career. In this context, adolescent research has largely been problem-focused—aiming to identify and rectify deviations from normative patterns of development (Gillies, 2000; Rattansi & Phoenix, 2005) or addressing the difficulties of “adolescence”, which are often linked to an inherent
immaturity and associated with irresponsible and sometimes dangerous behaviour (Kehily, 2007).

Within this body of knowledge, adolescence is generally positioned as a universally occurring stage of life that, while primarily driven by biological maturation, may be influenced by social context (France, 2007; Wyn & Woodman, 2006). However, critics of this perspective argue that this assumption of universalism ignores the vast diversity in how this “stage” of life has been understood, both between and within cultures over time, (Claudio, 1998; Hopkins 2010; Mizen 2004). While a period akin to adolescence is common across many societies (Richter, 2006), it is far from universal. For example, in the South East Asian culture of Hmong, the age of 12–13 marks the end of childhood and start of adulthood, while in parts of Bangladesh, developmental status is linked to social class and work status, rather than age per se (Tobin & Friedman, 1984). In addition, some of the key developmental tasks identified as relevant to adolescence in modern-western societies—such as identity formation—appear to be less salient for young people living in societies that are more collectivist in nature or those with more prescribed adult social roles (Kroger, 2006). As will be subsequently discussed in more detail, our current preoccupation with individual identity and the related notion that “finding ones’ self” is a legitimate and necessary pursuit, is a relatively recent phenomena and arguably tied to the specific cultural, political and economic context of contemporary western society.

In contrast to more positivist understandings of adolescence, sociological approaches emphasise that the expectations, demands and challenges young people face are heavily culturally bound and therefore propose that “youth” is a “social process” (e.g. Wyn,1997). In this sense, youth is defined as a fluid and dynamic social construct, with its meaning changing over time, place and the context in which it is being used (Hopkins 2010; Mizen 2004). Rather than attempting to categorise youth by specific age ranges or biological
changes, sociologists have proposed that the boundaries of youth are often prescribed by state policies that grant individuals different rights and responsibilities at certain ages (France & Threadgold, 2016; France, 2007). Youth studies in its current form can be traced back to the late 1970s, and although has largely grown out of a sociological tradition, encompasses a diverse range of perspectives (Woodman & Bennett, 2015a). Within this, youth research has often (but not exclusively) been loosely grouped into “transitional” or “cultural” approaches (Buckingham, 2008; Furlong, Woodman, & Wyn, 2011).

While both transitional and cultural approaches to youth research developed during the same period of rapid social and economic change in the mid to late 20th century, they have been relatively separate and dominated by different methodological techniques. Transitional research has largely employed quantitative methods to identify patterns in the way young people transition between education and the full time labour market, and to elucidate how structural inequalities impact these transitions (Woodman & Bennett, 2015b). Alongside this transitional body of work grew the “cultural” approach (Furlong & Cartmel, 2007; Gillies, 2000). This branch of youth studies has generally focused on ethnographic methods, considered more suited to the tasks of understanding meaning-making processes, elevating youth voices and highlighting their resistance to the status quo (Bennet, 2002).

More recently, the concept of “social generation” has been proposed as a more relevant and useful way to understand contemporary youth in an age of social and economic change (Buckingham & Willett, 2006; White & Wyn, 2013; Woodman & Wyn, 2015). This conception of generation is premised upon the work of mid-20th century sociologists like Mannheim (1952), who proposed that the process of ageing and life-course progression is profoundly mediated by social change. Proponents of a social generation approach, such as Woodman and Wyn (2015) argue that it is this emphasis on the intersection of social conditions and individual subjectivities that makes it such a valuable framework to
understand youth experiences, including youth mental health. From a social generation perspective, the specific social, political and economic conditions of a given time and place create both opportunities and risks that young people need to navigate (Woodman & Wyn, 2013; 2015). Within this approach there is also an emphasis on the diversity of individual experience and young people’s own meaning-making processes (White & Wyn, 2013; Woodman & Wyn, 2015).

Utilising a framework such as a social generational approach allows for the recognition that youth is negotiated in a cultural context that shapes the way young people both experience and express mental health difficulties and recovery. While acknowledging the influence of physiological and psychological changes on young lives, it is this social generational approach to youth research that underpins the present study. That is, I will take the position that developmental stages are fluid and dynamic social constructs that incorporate biological and psychological components. Like the social generation perspective described above, this research aims to illuminate both unique and personal meaning-making processes that young people engage in, as well as the cultural context that shapes their experiences of mental health difficulties and recovery. In keeping with this more sociological perspective, I will refer to “youth” rather than adolescence throughout, regardless of the language used in reviewed literature. Exceptions to this will be made in the case of direct quotes or specific service names.

In summary, this research is premised on the notion that the present social context is not only relevant to how we conceptualise youth, but also that some of the challenges and stresses young people face in contemporary life may increase their vulnerability to experiencing mental health difficulties. The following section aims to explore this in further detail, locating New Zealand “youth” in their contemporary socio-cultural context and
highlighting some of the suggested implications of this, with a specific focus on mental health and well-being.

**Socio-cultural context of contemporary youth.**

The way that young people live their lives has changed greatly over recent decades and this has created a range of poorly understood but probably critical pressures that affect their psyche and behaviour.

(Gluckman, 2017)

Youth researchers, and sociologists more generally, are in agreement with the sentiment expressed above—that young people today face unique challenges related to living in a world profoundly different from the one their parents or grandparents inhabited (Furling & Cartmel, 2007; Woodman & Wyn, 2015). Rapid changes in education, work, relationships and family life have occurred since the middle of the 20th century, leading to contemporary western society being referred to as “late” or “high-modernity” (Beck, 1992; Giddens, 1991a). One prominent theory that attempts to make sense of these changes is “individualisation” (Bauman, 2000; Beck & Beck-Gernsheim, 2002; Giddens, 1991a). While variation exists between the exact claims of different individualisation theorists, overall they share the view that through these social, economic and ideological changes, the individual has become the central unit of society and individual behaviour is now less strictly bound by traditional social structures and norms (White & Wyn, 2013). As a result, life-course has become much less of a collective experience and life transitions—for example, between school and work or from dependence on family of origin to independence—have become much less prescribed. While these changes do not only impact young people, it has been suggested that it is their experiences that has been most reshaped or influenced by them (France & Threadgold, 2016; Woodman & Wyn, 2015).
It has been argued that protracted and de-sequenced transitions to adulthood in the context of a rapidly changing environment, has put new pressures on young people, which have contributed to increased mental health difficulties in youth populations (Furling & Cartmel, 2007; Rutter & Smith, 1995; West and Sweeting 2003). Changes to education systems and labour markets are one aspect of the late-modern society that have been suggested to have increased stress for young people. Prior to the 1970s, the transition from education to work was considered potentially stressful but a typically linear and unproblematic process (Furlong et al., 2011; White and Wyn, 2013). However, social change has led to this transition becoming increasingly complex and drawn out, with young people spending longer in education—often while working part-time—but delaying entry into the full-time labour market—and thus delaying entry into other “adult” roles such as marriage and parenthood (Woodman & Bennett, 2015). This led theorists to refer to “arrested”, “yo-yo” and “non-linear” transitions (Biggart & Walther, 2006; Cote, 2000; Du Bois-Reymond & Lopez Blasco, 2003). It has been proposed that these delayed transitions into full-time work, although increasingly normative, have impacted other aspects of young people’s lives and subsequently had a negative impact on mental health.

While there is limited New Zealand research directly relating to this, some international research conducted in societies similar to New Zealand offers relevant insight. Wyn and Andres (2011) drew on a comparative analysis of longitudinal data from Australia and Canada to support claims that since the 1990s, young people’s ability to move into an adult life (in ways they value) has been hindered by neo-liberal education and labour market policies, which has ultimately impacted their mental health. The data indicated that it took approximately 14 years post-secondary school before the majority of both groups of young people had permanent or secure jobs. Young people, especially in Australia, described the struggle to gain employment security as dominating other areas of their life. Both groups
found it difficult to achieve the long-term goals they had described at age 22 (including long
term partnership, marriage and parenthood). The authors argued that the failure to live up to
their hopes and dreams, the long-term experience of uncertainty in employment and personal
relationships, and subsequent low fertility rates impacted negatively on young people’s
health and well-being, especially in Australia. Wyn and Andres (2011) suggested that young
Australians’ experienced greater “transitional issues” than the Canadian group because of the
higher rates of casual employment and long, unstandardized working hours prevalent in
Australia. Those in the Australian sample were also more likely to express concerns about
their mental health, and over 40% of university educated women in the Australian group
considered themselves mentally unhealthy (Wyn & Andres, 2011).

This weakening of traditional social structures and increased variability in life-course
trajectory, means that individuals in late-modern societies have “no choice but to choose how
to be and how to act” (Giddens, 1994). While some theorists suggest this has the potential to
lead to increased opportunities and freedom (Giddens, 1994), others emphasise the
considerable burden associated with continuous process of choice and decision-making that
is required in lieu of social structures guiding life-course (Baumeister & Muraven, 1996;

In his 2004 work The Paradox of Choice, social psychologist Barry Schwartz links
the proliferation of choice to increasing rates of mental health difficulties. He argues that,
while some freedom and autonomy to choose is pivotal to wellbeing, constantly having to
weigh up excessive amount of choice reduces capacity for other endeavours that research
indicates promote wellbeing, such as investing time in the quality and quantity of social
relationships. Schwartz also argues that the proliferation of choice has led to raised
expectation levels which subsequently results in people being more easily and frequently
disappointed by the outcome of their choices. As this takes place in an environment that
strongly emphasises individual responsibility, when choices lead to disappointing outcomes people are likely to feel that they have only themselves to blame (Schwartz, 2004). It is important to note that not all contemporary young people live in an environment characterised by prolific choice and freedom, with many young people around the globe living in societies that have strictly enforced moral codes and rigid social expectations which lead to their own set of challenges (Basmenji, 2013; Jeffery, 2018).

Theorists have also proposed that the freedom of choice in contemporary western societies is profoundly linked to our current pre-occupation with identity, which has been suggested to be of particular relevance to young people (Baumeister & Muraven, 1996; Giddens, 1991b). Due to the de-standardisation of life-course, “adulthood” itself is now a more fluid construct and something individuals are required to actively invent for themselves, rather than a stage of life one evolves into (Beck & Beck-Gernsheim, 2002). Young people living in late-modern societies like New Zealand are now much less likely to be tied to specific adult paths on the basis of gender or family background. In addition, the diversity of job opportunities that have emerged since the processes of industrialisation and urbanisation, and the related increase in geographical and social mobility, mean that contemporary young people are faced with a plethora of choices (Baumeister & Muraven, 1996). Simultaneously, Western society has also allowed for a more tolerant, pluralistic value system in which basic values are now understand as “personal values” rather than being determined by religious or strict moral codes.

Whilst there are obvious benefits to this increased freedom—such as being less likely to be locked into an unwanted career or marriage—the lack of a clear basis on which to make life choices can pose particular challenges for contemporary young people (Baumeister & Muraven, 1996). It has also been suggested that this rapidly evolving social change has led to an environment of uncertainty that forces people to constantly renegotiate their identity in
light of changing experiences (Beck, 1992; Giddens, 1991b). Due to the rapid rate of change, young people are less able to look to their parents or older members of their community for guidance or modelling about how best to engage with this active process of shaping their lives, and themselves (Woodman & Wyn, 2015).

Migration and ethnicity have also been posited as being relevant to understanding the experiences of contemporary young people (Furlong, 2013; White & Wyn, 2013). It is estimated that there are 244 million international migrants, with more people than ever before living in countries other than where they were born (International Organisation for Migration, 2018). Since the 1840 signing of the Te Tiriti o Waitangi/The Treaty of Waitangi between some indigenous Māori and British settlers, New Zealand has been considered a bi-cultural country. However, New Zealand is increasingly becoming “multi-cultural”: Statistics from the 2013 Census revealed that 74% of the New Zealand population identified with at least one European ethnicity, 15% of people identified with Māori ethnicity, 12% with at least one Asian ethnicity, 7% with at least one Pacific ethnicity and 1% with at least one Middle Eastern/Latin American or African ethnicity (Statistics New Zealand, 2014). Within this, many people identify with more than one ethnicity, and recent statistics specific to youth suggest that 42% of New Zealand secondary school students identify as belonging to more than one ethnic group (Clark et al., 2013). This cultural diversity is likely to continue to increase in New Zealand, with the number of people migrating to the country trending upwards since 2012 (New Zealand Immigration Statistics, 2018).

There are a number of opportunities and potential risks associated with the complex phenomena of international migration. In many cases, ethnic minorities—both migrants and indigenous people—are considered outsiders in the societies they live in (White & Wyn, 2013). In this increasingly complex environment, people often carry multiple, sometimes conflicting identities (Josselson & Harway, 2012) and it has been suggested that young
people who identify as indigenous or ethnic minority may face added complexity to the task of actively constructing and defining their identity (Butcher & Thomas, 2003; Paradies, 2016). Considering the current demographic make-up of New Zealand society, this complexity likely applies to many young people in this country. One recent New Zealand study suggested that people who identified as Pacific with mixed ancestry are more likely to experience lower levels of subjective well-being and increased identity tension (Manuela & Sibley, 2014). As detailed in the previous section, young Pacific and Māori people in New Zealand are more likely to attempt suicide and complete suicide respectively, compared to other ethnic groups (Clark et al., 2013; Ministry of Health, 2016). There is also a significant body of international research that suggests ethnic minorities have higher rates of mental health issues (Kake, Arnold & Ellis, 2008; Read, 2004; Sachdev, 1997) and evidence to suggest that this can be accounted for by increased levels of economic and social disadvantage (Tinghög, Hemmingsson, & Lundberg, 2007). New Zealand and international research suggests that poverty is a significant risk factor for mental health difficulties (Moffit et al., 2011; Read, 2004).

In summary, young people in New Zealand, like those in many other western societies around the world, are living in a rapidly changing socio-cultural context which presents a particular set of challenges. It has been suggested that this environment may increase young people’s vulnerability to experiencing mental health disorders, and thus partly account for a rise in prevalence of youth mental health difficulties (Bor et al., 2014; Furling & Cartmel, 2007; Gluckman, 2017). The following section will outline the services in New Zealand that are designed to support young New Zealanders who are experiencing mental health difficulties. I will also draw on both local and international literature to outline some of the challenges facing these youth mental health services.
Youth Mental Health Services in New Zealand

In New Zealand, mental health services are provided to young people in the context of specialised child and adolescent mental health services (CAMHS), or youth mental health services. Young people accessing secondary mental health services are eligible for these specialist services until the age of 18 or 19, after which age they are referred to adult mental health services (Auckland District Health Board, 2018; Base Dunedin, 2018; Te-Upoko-me-Te-Karu-o-Te-Ika: Mental Health, Addictions and Intellectual Disability Service, 2017). Exceptions to this exist in specialised services, such as early psychosis intervention teams, which typically accept young people up until the age of 30 (Auckland District Health Board, 2018; Canterbury District Health Board, 2013), or specialised eating disorder services which accept clients across the lifespan (Eating Disorder Association New Zealand, 2018). The demarcation of services by age is typical of modern western healthcare systems, despite youth being a relatively fluid developmental stage (Singh, 2009).

Youth mental health services usually encompass a multi-disciplinary team of mental health professionals, including psychiatrists, psychologists, occupational therapists, nurses, social workers and peer support staff (Auckland District Health Board, 2018; Base Dunedin, 2018; Te-Upoko-me-Te-Karu-o-Te-Ika: Mental Health, Addictions and Intellectual Disability Service, 2017). Inpatient and community services function relatively independently, although do tend to work together when a person is transferred from one setting to another. More recently, non-governmental organisations have also played an increasing role in mental health service provision in New Zealand, receiving funding to provide a range of services including respite care, community support, housing and education support and advocacy (Ministry of Health, 2014).

Medication is often the primary method of intervention provided by mental health services in New Zealand McGorry et al., 2005; Royal Australian and New Zealand College
of Psychiatrists Clinical Practice Guidelines Team for Bipolar Disorder, 2004; Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Depression, 2004). Evidence suggests that New Zealand has seen a significant rise in the use of psychiatric medication in the last two decades. Recent estimates suggest that annual rates of anti-depressant prescription in New Zealand, increased by 37% between 2006 and 2012, with about 412, 631 people currently taking this type of medication (Read, Cartwright, & Gibson, 2014). A similar trend has been identified in regards to anti-psychotic medication, with a 49% increase in prescription rates between 2008 and 2015 in New Zealand. Although non-pharmacological approaches have been stated to be preferred for people under 18 years of age who have depression or anxiety disorders, rates of antidepressants prescribed to this age group were 44 percent higher in 2014 than in 2010 (Best Practice Journal, 2018).

Likewise, the amount of antipsychotic medication dispensed to people aged 10–17 years increased by 48 percent in the same time frame. This upward trend in prescription and use of psychiatric medication to treat mental health difficulties in people of all ages, has been criticised for a number of reasons, including on the basis of significant associated side effects and questions about the quality of the evidence-base used to promote the efficacy of these medications (Gøtzsche, 2014; Read et al., 2014).

Talking therapy is also offered as part of public mental health service provision in New Zealand, including in youth and CAMHS settings. In recent years, Cognitive Behavioural Therapy (CBT) has largely dominated the talking therapies offered in public mental health settings. This has been attributed to its large evidence base and time limited nature (Te Pou o Te Whakaaro Nui, 2009). More recently, so called “third wave” behavioural therapies such as Dialectical Behavioural Therapy (DBT) and Acceptance Commitment Therapy (ACT) have gained in popularity. If a young person in New Zealand is not eligible for secondary mental health services, but meets criteria for mild–moderate
depression, they can be referred for four to six subsidised sessions of psychological therapy (often CBT) through a Primary Health Organisation (Christchurch PHO, 2018; ProCare Health, 2018). General Practitioners (GPs) tend to act as gatekeepers to these services through the process of diagnosis and referral. In the case of sexual trauma, therapy is funded through Accident Compensation Corporation (ACC), providing the event(s) occurred in New Zealand (Te Pou o Te Whakaaro Nui, 2009). Many young people in New Zealand can also access non-intensive counselling services through their education providers—school guidance counsellors at high school and through student health centres for those who attend tertiary education.

While CBT, and now third wave behavioural therapies such as ACT and DBT, propose to offer an evidence-based approach to psychological treatments, this claim has been critiqued on a number of levels. Firstly, the evidence base for these therapies has largely been developed in the United Kingdom, Europe and the United States, with little research completed on talking therapies for Māori, Pacific, Asian, and other ethnic minority populations in New Zealand (Te Pou o Te Whakaaro Nui, 2009). In relation to the specific evidence base for using CBT to treat youth mental health issues, a number of methodological factors have been highlighted, including the tendency to cite outcome results for those who complete treatment, rather than for the total sample who started treatment; and citing successful response to CBT for a primary anxiety disorder (for example), despite the presence of significant co-morbid symptoms (Albano & Kendall, 2002). CBT is typically focused on a client’s specific presenting problems, and less focused on exploring deeper underlying issues and past experiences (Beck, 2005; Mansell & Taylor, 2012). This reflects the trend observed during the late 20th century of mental health treatment development and research moving away from non-specific interventions, towards targeting specific disorders (Hibbs & Jensen, 1996; Kazdin & Weiz, 1998).
There are a number of pressing issues currently facing public youth mental health services in New Zealand (Allan, 2018; Mental Health Commission, 2006, 2011). In New Zealand, community and inpatient mental health and addiction services are designed for the 3% of the country’s population who have the highest and most complex mental health and addictions needs. However, this target was set in 1994 and whether it is still appropriate for the current level of need has been called into question.

Lack of funding poses significant challenges to all mental health services in New Zealand: between 2006/2007 and 2016/2017, funding was increased by 40%; however, the number of people accessing services increased by 73% (Allan, 2018). Funding for primary mental health services has remained almost unchanged over the past 5 years. In 2015/2016, child and youth mental health services received only 11% of the total DHB funding for mental health and addictions services (Allan, 2018), despite New Zealand research suggesting that more than 50% of those diagnosed with a mental disorder will experience onset before the age of 18 (Oakley Browne et al., 2006). The Mental Health Commissioner recently highlighted that youth mental health services in this country are under increasing pressure and that “some young people may be missing out on early intervention because of overly restrictive criteria to access services” (Allan, 2018, p. 78). Concerns have also been raised about the lack of funding increases for non-governmental organisation (NGOs), despite cost increases (Platform Trust, 2014).

Accessibility of mental health support for young people has been a key area of concern for a number of years, especially for those with issues of mild-medium severity (Mental Health Commission, 2011). Addressing this issue is one of the goals of the recently launched Prime Minister’s Youth Mental Health Project (Ministry of Health, 2018). Many young people are only able to access secondary services once they reach crisis point (i.e. a suicide attempt). At the other end of the severity spectrum, the lack of appropriate inpatient
services for young people has also been highlighted and there have been many calls for a greater focus on prevention and early intervention (Allan, 2018; Gluckman, 2017; Health Commission, 2012). Collaboration within and between service providers and sectors, especially during transition periods and for young people with multiple issues, has also been identified as requiring urgent improvement (Allan, 2018; Mental Health Commission, 2006; 2010; 2011).

Paradoxically, there is also a significant issue with service under-utilisation by young New Zealanders: while there is evidence to suggest that the rate of child and youth access to mental health services has been gradually increasing, latest available figures indicate this is still below Ministry of Health’s target of 3% (Mental Health Commission, 2011). Results from one New Zealand study showed that less than 25% of young people with a mental health diagnosis sought any form of formal treatment (Fergusson, et al., 1993; Horwood & Fergusson, 1998). These figures are in line with international findings that suggest about only one third of the young people who are eligible for mental health support, actually access it (Friedman, Katz-Levey, Manderschied, & Sondheimer, 1996; Rutter & Stevenson, 2008; De Haan, Boon, Vermeiren, & de Jong, 2013; Meltzer, Gatward, Goodman, & Ford, 2000; Zachrisson, Rödje, & Mykletun, 2006). International findings also suggest that many young people who do engage with mental health interventions, terminate engagement prematurely (Baruch, Vrouva, & Fearon, 2009; Lai, Pang, Wong, Lum, & Lo, 1998; Luk et al., 2001; Navridi & Midgley, 2006) and that those that do terminate early, may face worse outcomes (de Haan et al., 2013).

Within youth as a group, variation exists in regards to treatment utilisation. In New Zealand, specialised mental health service utilisation is particularly low for Māori and Pacific Island youth, and young males are less likely than females to seek help from a health professional for mental health or emotional concerns (Adolescent Research Group, 2008;
Ministry of Health, 2008). Results of the Youth2000 survey suggested that over 80% of young people experiencing significant mental health problems did not seek help from their GP (Mariu, Merry, Robinson, & Watson, 2012). This fits with international findings that suggest young people do not view their GPs as the appropriate person to manage mental health issues (G. Leavey, Rothi, & Paul, 2011). As GPs largely act as gatekeepers to secondary mental health services, low GP engagement has been suggested to contribute to low youth service utilisation rates (Mental Health Commission, 2011). International figures also suggest that dropout rates for young mental health service users are comparatively higher than other age groups (Block & Greeno, 2011; Edlund et al., 2002). A recent international meta-analytic review regarding dropout from Child and Adolescent outpatient care identified several robust predictors of treatment dropout, including: being part of an ethnic minority; having lower socio-economic status; perceiving a lower quality of therapeutic relationship; perceiving lower relevance of treatment, and; perceiving the clinician as not showing care and concern (de Haan et al., 2013).

To raise the profile of widespread concerns about mental health services in New Zealand, including those serving young people, ActionStation—an independent, community campaigning organisation operating in New Zealand—published the People’s Mental Health Report (Elliott, 2017). The report was spearheaded by mental health advocates Kyle McDonald and Mike King, in response to funding cuts and an increasing number of New Zealanders being unable to access services. More than 500 stories were submitted for the report, by people who had used or tried to use services, those who worked in mental health services and also family members of people who either used or worked in these services (Elliott, 2017). Ninety-four of these stories were about children and young people. The authors reported that 93% of the stories were mostly focused on problems or challenges associated with using or working in the mental health system, and that the report provided
insight into some of the challenges currently facing the mental health system in this country. A thematic analysis identified a number of key themes from these 500 stories. People spoke about having difficulty accessing appropriate mental health services in a timely manner, and many reported only getting help when in crisis. People also talked about a lack of treatment options and an over–reliance on medication. Both those who worked in mental health and those who used services, described the mental health workforce as stressed, overworked and under–resourced, leading to negative outcomes for service users and staff (Elliott, 2017).

In summary, a number of pressing issues currently face the mental health system in New Zealand, including youth services. Amid concerns about lack of appropriate and timely mental health support for young people, exists a trend of service underutilisation and high rates of early treatment termination (Edlund et al., 2002; Mariu et al., 2012). Although there are likely a number of complex, interrelating factors contributing to these patterns, it has been suggested that one partial explanation is that mental health services have not been developed with young people’s priorities in mind (McGorry et al., 2013).

The provision of mental health services for people of all ages in New Zealand is primarily guided by the principle of recovery (Health and Disability Commission, 2001; Ingleby, 1985; Mental Health Commission, 2012). The Ministry of Health describes a recovery approach as “supporting individuals in a way which minimises the level of distress and impact on their lives as much as possible” (2018), while in an influential New Zealand policy document, Blueprint II, recovery was described as living well in the community regardless of a return to full health (Mental Health Commission, 2012). In the same document, strong emphasis was also placed on engaging with service users and their whanau and family to ensure mental health services are grounded in a person-centred approach (Mental Health Commission, 2012).
While this commitment to the philosophy of recovery appears to encourage a more holistic approach to mental health issues, there is a significant gap in the existing literature regarding what recovery means for young people, and how young people utilise mental health services to support their recovery. This research aims to make a contribution to closing this research gap. If youth mental health services in New Zealand are to genuinely adhere to a person-centred, recovery approach, it is imperative to listen to young people’s perspective regarding their experiences of mental health difficulties, how they understand and describe recovery and what role services may or may not play in this process. In the following section, the concept of recovery will be described and defined and the impact of the recovery paradigm on mental health services both in New Zealand and internationally will be discussed, including the rise of active service user involvement in service provision. This will then be contextualised in the context of contemporary New Zealand and situated in dominant discourses related to personal responsibility and self-improvement. Following this, existing literature that explores youth perspectives of mental health difficulties, recovery and service use will be outlined to illuminate what we currently know, and what areas need further exploration.

**Recovery Paradigm**

Since the early 1990s, the recovery paradigm has become increasingly influential in mental health systems, especially in New Zealand, Australia, Canada, UK and the USA (Ahmed et al., 2012; Tew et al., 2012). This approach to mental health service provision grew out of the personal recovery movement. During the second half of the 20th century, widespread de-institutionalisation of the mental health system occurred in much of the western world, including New Zealand. This de-institutionalisation has been attributed to the development of psychotropic medication, a desire to reduce the financial burden of state
funded mental hospitals and asylums, and the view that treating people in the community was more effective (Bassuk & Gerson, 1978; Prout, 2007). However, in the wake of de-institutionalisation, mental health services were criticised for lacking a cohesive and effective approach to providing support (Test, 1984). Mental health care during this period was also criticised for perpetuating the idea that people living with mental health difficulties had incurable symptoms and faced a lifetime of medicated symptom management (Mead & Copeland, 2000). It was against this back drop that service users and advocates worked to promote an alternative version of “mental illness” and how best to support people living with such experiences. It was through this work that the idea of “personal recovery” was born.

The underlying philosophy of recovery is that people living with mental health issues deserve more than just symptom relief and have the potential to live satisfying, meaningful lives (Anthony, 1993; Davidson, O'Connell, Tondora, Lawless, & Evans, 2005). While “clinical” recovery is generally focused on overcoming symptoms through effective treatment, “personal” recovery is concerned with wider holistic wellbeing and the person rebuilding a worthwhile life (Slade, 2009; Tew et al., 2012). Since the beginning of the service user and recovery movement, empowerment, self-direction and choice have been at the core of the recovery model (Chamberlin, 1978; Mead & Copeland, 2000). In adult mental health recovery literature, recovery is described as involving or being supported by interactions with professionals and services, but not dependent on them (Jacobson & Greenly, 2001). Authors of a recent qualitative study into adult recovery and service use concluded that the process of recovery often starts before people begin using services (Biringer, Davidson, Sundfør, Lier, & Borg, 2016).

To a large extent, the concept of recovery has been developed out of personal accounts of experiences of mental health difficulties (Brown, 2008; Deegan, 2002; Lapsley, Nikora, & Black, 2002; Spector-Mersel & Knaifel, 2017; Thornhill, Clare, & May, 2004).
Researchers highlight that recovery is an inherently subjective concept that can be challenging to define, in part due to the personal nature of the recovery process and also the heterogeneity of outcomes associated with mental health issues (Davidson et al., 2005; Wyder & Bland, 2014). One often cited paper that provides lived experience perspectives on recovery offers five key facets of recovery: Hope, individual responsibility, education and information sharing, advocacy, and peer support (Mead & Copeland, 2000). Another commonly used definition by Anthony (1993) describes recovery as a complex and time consuming process that doesn’t just include recovery from mental illness, but also from discrimination and internalised stigma, fall-out from treatment settings, lack of self-determination and loss of hopes and dreams.

In an attempt to identify commonalities among unique, personal recovery experiences, a number of recovery “models” have been proposed. Jacobson and Greenly (2001) describe recovery as requiring both internal and external conditions. Internal conditions refer to attitudes, experiences and internal processes of change and are described as encompassing hope, healing, empowerment and connection. The external conditions they describe encompass circumstances, events, policies and practices that are conducive to recovery, and include human rights, a positive culture of healing and recovery oriented services (Jacobson & Greenley, 2001). This model differs from some of the others proposed, due it its explicit reference to external and environmental factors that influence the personal process of recovery. Andresen and colleagues (2011) describe four processes of personal recovery as including finding and maintaining hope, re-establishing of positive identity, building a meaningful life and taking responsibility and control. Glover (2012) also emphasises personal control and responsibility and outlines five recovery processes: transition from passive to active sense of self; shift from hopelessness and despair to hope; movement from...
others in being in control to personal control and responsibility; feelings of alienation to
discovery; feelings of disconnectedness to connectedness.

Leamy and colleagues (2011) conducted a systematic review of 97 papers to
synthesize common themes among different models and definitions of recovery and
presented their findings as a conceptual framework of recovery. They identified five core
recovery processes which they referred to by the acronym CHIME: (social) connectedness;
hope and optimism about the future; identity; meaning in life; and empowerment (Leamy,
Bird, Le Boutillier, Williams, & Slade, 2011). Social connectedness included relationships
with others, being part of a community and support from others. Hope and optimism about
the future included belief in the possibility of recovery, motivation to change and having
dreams and aspirations. Identity included rebuilding a sense of identity and overcoming
stigma. Meaning in life included having meaningful goals or social roles, finding meaning in
experiences of mental illness, and spirituality. Finally, empowerment included having control
over life and personal responsibility for ones wellbeing (Leamy et al., 2011). As part of the
framework, the authors also identified a number of “characteristics” of recovery, including
that recovery is an active, unique, individual, non-linear process that was described as a
journey, a struggle, and gradual. The authors also identified that in recovery studies focused
on ethnic minorities, participants emphasised the impact of stigma, both related to mental
health issues but also to culture, race and ethnicity (Leamy et al., 2011).

There has been very limited New Zealand specific research into recovery. One
notable exception to this is work by Lapsley and colleagues (2002). They interviewed forty
Māori and non-Māori participants aged 26–66, who considered themselves recovered from a
disabling illness that was quite some time in the past. Through a process of narrative analysis,
the researchers identified that these participants described recovery occurring across a
number of dimensions including: ongoing psycho-social issues; acute stressors; symptoms of
mental ill health; fear and anxiety surrounding symptoms and possible re-occurrence; treatments; consequences of the mental health problems; destruction of self-esteem; trust, optimism, hope and faith in the future, and; the stigma associated with mental ill health (Lapsely et al., 2002). They identified three main stages of recovery: A “glimpse of recovery” which was described as a few positive changes occurring that lay the foundation for a turning point; the “turning point”, which described a rapid series of events of sequence of whereby people took charge of their situation, gained hope and developed new insight, and; the “road to recovery” which described that once the impetus for recovery was established, there was still a long way to go. They also captured the process of change that occurred in relation to self-identity by using the word HEART: hope; (self-) esteem; agency; relationship; transitions in identity (Lapsely et al., 2002). The findings of this study largely fit with those studies included in the Leamy et al., review (2011).

**Implementation of recovery.**

A recovery–oriented environment is generally described as one that facilitates the recovery processes described above (Davidson et al., 2016; Deegan 1995). Over the last twenty years, personal recovery has been described as providing a philosophy to guide the development of more inclusive, responsive and person-centred mental health services (Ahmed et al., 2012; Jacobson & Curtis, 2000). Since the publication of the 1998 report *Blueprint for Mental Health Services in New Zealand*, mental health services in New Zealand have been required to adhere to a recovery approach (O’Hagan, 2004) and the recovery model has since been nominally endorsed by key governing bodies and guided a number of important policy documents (Mental Health Commission, 1998, 2012; Ministry of Health, 2006, 2012, 2018).

One of the practical implications of the influence of the recovery model on mental health service provision has been the proliferation of peer-led interventions and service user
consultation (Ahmed, 2015; Repper & Carter, 2011). This partly reflects the notion that being actively involved in the planning, development and implementation of mental health services is an important part of the recovery process (Deegan, 1996; Walsh, 1996). The development of peer-led interventions is also grounded in the privileging the value of “lived” experience that underpins the recovery movement. That is, that people who share similar experiences can provide a deep level of empathy, validation and hope to another person pursuing recovery from mental health issues (Dennis, 2003). Peer-led interventions encompass a wide range of mutual and self-help programmes, consumer-run services and peer support, which often differs from other peer-led interventions in that it is generally offered within the context of traditional mental health service settings (Myrick & del Vecchio, 2016).

Latest figures (2014) show that in New Zealand the peer workforce accounts for 3% of the mental health and addictions workforce, and that this number is growing (Allan, 2018; Te Pou o te Whakaaro Nui, 2014). This number includes peer support specialists and consumer or family/whanau advisors. Unlike peer support specialists who work directly with service users, consumer (and family/whanau) advisors present systemic consumer views and play a role in the strategic development, planning, implementation and evaluation of mental health services in New Zealand (Allan, 2018; Te Pou o te Whakaaro Nui, 2014). There are also consumer-run and consumer-managed networks in New Zealand that operate outside of, but often contribute to, mainstream mental health services (Ministry of Health, 1995).

Strengthening the participation of service users and developing more peer-led interventions were identified as priorities in two recent influential policy guideline documents (Ministry of Health, 2012, 2017), although the nature of this implementation is at present unclear (Allan, 2018). It has been noted however, that while including peer-led
intervention into the mental health workforce is consistent with the recovery paradigm, their addition alone does not create a recovery centric environment (Slade et al., 2014).

A recent study exploring the experiences of New Zealand peer support specialists, highlighted a number of issues related to complex dynamics between clinical and peer staff, and the disjuncture between recovery values and dominant medical model, including specific issues relating to compulsory treatment and coercion (Scott, Doughty & Kahi, 2011). At a policy level, international research indicates that even when stakeholders are in favour of service user participation and there is a legislative framework to support this, actual service user participation in the development of policy, legislation and service implementation may be poor (Kleintjes, Lund, Swartz, Flisher, & MHaPP Research Programme Consortium, 2010).

The elevation of lived experience perspectives and the personal recovery paradigm offers a counter narrative to the clinician and researcher perspectives that have traditionally dominated the literature and guided service provision. However, user-centred notions of recovery have also been developed and shaped by our contemporary cultural context. In line with the theoretical framework underpinning this research, the following section will aim to contextualise recovery in present day New Zealand and will foreground some of the dominant discourses surrounding mental health and wellbeing that may influence how young people make sense of their experiences of mental health difficulties and personal recovery.

**Contextualising recovery and mental health service use.**

mental health is strongly influenced by social determinants such as unemployment, low income and low standards of living and points to evidence that prenatal and early childhood experiences—which are also linked to social factors—contribute to poor mental health outcomes later in life (Gluckman, 2011; Ministry of Health, 2011).

These allusions to social causes of mental health difficulties, and governmental/collective responsibility for their prevention and treatment, are somewhat incongruous with dominant discourses surrounding mental health and recovery, which to a large extent de-emphasise social contributors to mental health problems and foreground the importance of individual responsibility and personal agency. The following section will contextualise youth experiences of mental health difficulties and recovery within current dominant discourses of individual responsibility for health and wellbeing, personal agency and self-improvement. It will also describe the influence of what has been referred to as the “psy” complex and influence of the self-help movement in perpetuating these ideas.

Young New Zealanders’ experiences of mental health difficulties and recovery take place in the context of what Beck and Beck-Gernsheim refer to as the “individualisation of social risks” (2002, pg. 39). This refers to the idea that in contemporary society, social problems are perceived through a lens of individualisation and thus are conceptualised as personal inadequacies (Beck & Beck-Gernsheim, 2002; Furling & Cartmel, 2007). It has been argued that the promotion of “healthy lifestyles”, and associated encouragement for people to “take control” of their own health and wellbeing, including mental health, marks a wider shift, from society as a whole holding the responsibility of the health of its citizens, towards an emphasis on individual responsibility (Robb, 2007). It has been suggested that this emphasis on personal responsibility for health and wellbeing is in part perpetuated by professional discourses that locate problems within the individual including psychology and psychiatry (White and Wyn, 2013).
The “psy complex” is a term coined by Ingleby (1985) and expanded on by Rose (1990; 1996) that describes the pervasive influence of theory, discourse and analysis produced by psychology, psychiatry, psychotherapy and psychoanalytic disciplines in the mid-late 20th and early 21st centuries. Rose (1990; 1996) proposes that the influence of psychological knowledge is intricately linked to the individualisation of people in contemporary western society. It is proposed that the influence of these professions is not limited to people who actively engaged with them (through psychotherapy for example), but that psy ideas have been integrated into mainstream public discourse—with words such “psyche” and “ego” now part of everyday language (Rimke, 2000). Rimke sums up the link between psy discourse and individualisation when she states that popular psychology’s “unilateral focus on individuals contributes to a worldview which erroneously postulates that people can exercise control and mastery of themselves and their lives” (2000, p. 62). Rose (1999) suggests that the danger of such an emphasis on personal responsibility for health and wellbeing, is that it leads people to feel they have the freedom to “choose” health but that in fact, these choices are limited and not everyone is in an equal position to make them. White and Wyn (2013) argue that while those lucky enough to have a “strong constitution and very good social and institutional support” may be able to make the most of these choices and opportunities, for those who don’t “the burden of individual choice and responsibility weighs heavily” (p. 220).

The psy professions are not the only ones cited as playing a role in the perpetuation of discourse of personal responsibility for wellbeing and health. White and Wyn (2013) draw attention to the role the education system plays in this, pointing to work by Wright and Burrows (2004) that demonstrated how Year 4 and Year 8 New Zealand children (approximately 8–9 year olds and 12–13 year olds) gave accounts of “being healthy” that reflected the health and physical education syllabus emphasis on personal responsibility and
self-management of health. The authors did mention “very rare” (p. 226–227) occurrences of alternative constructions of health, including two Māori students who included more relational aspects of health in their answers (e.g. “take care of your friends” and “look after your elders”), highlighting the cultural specificity of health, despite its promotion as a largely universal concept. Work in an Australian context, demonstrated how school health curriculum positioned the failure of making “good choices” to ensure health and wellbeing as both immoral and irresponsible. White and Wyn (2013) suggest that these findings demonstrate how health education in New Zealand and Australia encourages young people to view their health primarily as a product of their personal choices, and that making bad choices around this risks being viewed as irresponsible, immoral and potentially resulting in poor physical or mental health outcomes.

The emphasis on individual responsibility, personal agency and self-management described above is also strongly reflected in definitions and models of personal recovery (Glover, 2012; Jacobson & Greenly, 2001; Leamy et al., 2011; Mead & Copeland, 2000). Highlighting the dominance of discourses that advocate for personal responsibility and empowerment is not to suggest that attempting to take ownership of ones’ wellbeing is inherently bad. Rather, it is to foreground the fact that it may be easier for some groups of people to successfully “take control” of their health and wellbeing than it is for others. In the context of dominant cultural discourses espousing the “freedom to choose” (Beck & Beck-Gernsheim, 2002; Beck, 1992; Giddens, 1991b), when things do go wrong, even if due to circumstances over which one has little control, the responsibility for this failure becomes a personal one (White & Wyn, 2013). This is perhaps particularly pertinent when considering young people, who are often limited in the amount of agency they can exert due to both legislative restrictions and cultural norms (France & Threadgold; 2016; France, 2007).
Personal recovery can also be understood in the context of a more general growth of the self-help and self-improvement industries. People living in late-modern societies such as New Zealand are bombarded with messages imploring them to be their “best self” through special diets, exercise regimes, self-help books, talking therapy and medication or supplements. The rise of the self-help movement can be considered to sit at the intersection between personal responsibility for wellbeing and our current preoccupation with “the self” which has been described as a key feature of contemporary society (Baumeister & Muraven, 1996; Giddens, 1991; Lash and Friedman, 1992). Self-help literature is often underpinned by the message that “change is always possible” and “if you believe in yourself you can do anything” (Gauntlett, 2008, p. 251). The “you can do anything” rhetoric that characterises self-help has been critiqued for perpetuating the idea that one is individually “responsible” for everything. On this, Rimke comments that “the self is conceived as possessing an inner reservoir of power that can be accessed. This suggests an intense accountability, responsibility, and sense of obligation that can be enlisted for choices and decisions” (2000, pg. 64).

It has been noted that self-reflection on one’s life, and how one relates to others is not new, and was previously the domain of ancient religious texts (Gauntlett, 2008). However others have been more scathing and suggested that self-help discourses are a manifestation of the continual need for self-improvement required in the context of extremely competitive labour markets (McGee, 2005). Rapping (1996) poetically critiqued the self-help and Alcoholics Anonymous recovery movement by saying it is not “mere shelter from the storm of modern life that we need to be seeking… it is the storm itself after all that is doing the damage. And staying dry, while important for survival, is not really our ultimate goal” (Rapping, 1996; p. 185). In other words, while a strong emphasis on taking responsibility for individual inner healing may help (some) people feel better, it comes with the risk of losing
impetus for broader social change and addressing the underlying causes of issues such as addiction. Gauntlett, (2008) argues that such a critique is an over simplification, and that both inner healing and advocacy for social change (or at least, resistance to inequality maintaining social structures) are not mutually exclusive. Personal recovery from mental health difficulties, while innately focused on unique, personal journeys, is also often described as including advocacy and the assertion of influence over mental health service provision (e.g. Leamy, 2011). In the New Zealand context, some of those leading the recovery movement aimed to explicitly foreground the importance of addressing stigma and discrimination, particularly in the context of post-colonial New Zealand (O’Hagan, 2004).

In New Zealand, the rise of the recovery paradigm has somewhat paradoxically occurred in parallel with the increasing influence of the bio-medical model. Read and colleagues (Read & Sanders, 2010; Read et al., 2008) argue that although the bio-psychosocial or stress-vulnerability model offered potential for true integration between psycho-social and biological research, in actual fact, psycho-social factors have been relegated to “triggers” of genetic vulnerability, rather than factors that can in and of themselves cause mental health difficulties. Read and Sanders (2010) point out that the vast majority of research into the cause of mental health problems since the mid-20th century has been focused on genetics and brains. A 2008 review of literature revealed that for every study exploring social causes of schizophrenia, there were 15 examining the biological causes (Read, Fink, Rudegeair, Felitti, & Whitfield, 2008).

The role of the pharmaceutical industry also been suggested as highly relevant when considering the dominance of the bio-medical model and wider social context of mental health issues is the late 20th and early 21st century (Read & Sanders, 2010). Critics point out that many researchers, journals and university departments have become dependent on the pharmaceutical industry for funding, which likely influences a bias towards bio-medical
approaches to understanding and treating mental health issues (Healy & Thase, 2003; Mosher, Gosden, & Beder, 2013; Shooter, 2005). This trend towards the medicalisation of mental health issues has been suggested to have significant implications for the identity of people whose difficulties have become associated with and defined by concepts of disorder, disease, pathology and dysfunction (Duncan, 2010). The influence of the biomedical model, although at odds with the concept of recovery in many ways, does contribute to a wider socio-cultural context in which mental health issues are primarily located within the individual.

Whilst the incorporation of recovery principles into mental health policy in countries like New Zealand has been hailed as supporting the development of more helpful and person-centred services, some of the dominant discourses reflected in the recovery paradigm that emphasise individual responsibility, personal agency and self-improvement can be understood to represent a double-edged sword. While on one hand these ideas can be understood as empowering, they have also been critiqued for overstating how much control people have over their own lives and for diverting attention away from the social causes of many of the problems faced in late-modern societies, including mental health difficulties. This emphasis on personal responsibility and agency may be particularly problematic for young people, who have ingrained structural and social limitations on the amount of agency they are able to exert over their own lives at particular ages and life stages. In addition, recovery literature and services user perspectives in general are largely dominated by adult voices (Bonney & Stickley, 2008; Jacobson & Greenley, 2001; Onken, Craig, Ridgway, Ralph, & Cook, 2007). There is a paucity of research into how young people view recovery and what it means for them. The following section will review the existing youth recovery and service use literature and highlight areas of potential difference between adult and youth perspectives on recovery.
Youth Perspectives on Mental Health Difficulties, Recovery and Service Use

As previously outlined, the recovery paradigm has largely developed out of the personal accounts of adults living with mental health difficulties (Slade, Williams, Bird, Leamy, & Le Boutillier, 2012). Researchers have suggested that considering the unique developmental tasks and challenges faced by young people, it is inappropriate to assume recovery principles are the same, or that adult recovery principles can be applied in the same way to young people (Honey et al., 2015; Ward, 2014; Ward, 2015). The presence of child and youth specific mental health services reflects an underlying premise that young people have specific needs in relation to their mental health. However, there is currently a dearth of research focusing on how young people experience recovery (Rayner et al., 2018; Ward, 2014). Likewise, research into youth service user perspectives and treatment preferences is also relatively sparse compared to literature focusing on adults. This is perhaps reflective of a traditional view that young people are not able to provide accurate information about themselves (Green, 2009; Prout, 2007). It has also been suggested that ethical concerns have hindered research with children or young people, with particular concern that no harm occurs to young people during the research process (Walker, 2001). However, there is growing recognition that young people are the most reliable source of information about their own lives and experiences (Morrow & Richards, 1996).

In line with this, it has been proposed that seeking out youth service user views may be crucial to improving mental health service provision and engagement (Buston, 2002; Claveirole, 2004; McGorry et al., 2013; Walker, 2001). The following section will review current research on youth perspectives—firstly in regards to experiences of mental distress and recovery more broadly, and secondly in regards to experiences with mental health service providers and interventions, such as medication and therapy.
Youth recovery.

A number of researchers have recently turned their attention to exploring youth recovery from mental health difficulties (Barnett & Lapsley, 2006; Bergmans, Langley, Links, & Lavery, 2009; J.E. Leavey, 2009; Mental health Coordinating Council, 2014; Rayner et al., 2018; Romano, McCay, Goering, Boydell & Zipursky, 2010; Simonds, Pons, Stone, Warren & John, 2014; Ward, 2014). One approach used to study youth recovery has been to ask young people, their family members and professionals if adult recovery models and concepts feel relevant to their experiences (Friesen, 2007; MHCC: Mental Health Coordinating Council, 2014). While still providing some much needed insight into youth recovery, this approach has been criticised for imposing existing frameworks onto participants and thus limiting the perspectives they share (Rayner et al., 2018). Other studies have taken a more open, bottom-up approach, whereby young people are interviewed without explicit reference to a prescribed recovery model or themes (Barnett & Lapsley, 2006; Simonds et al., 2014; Rayner et al., 2018; Romano et al., 2010). Findings from these studies, as well as related research on young people’s perspectives on wellbeing, will be outlined and discussed below. While researchers have tended to use different age parameters when exploring youth recovery, the views included in the studies outline below, tend to represent young people aged 14 to 29 years of age.

The Mental Health Coordinating Council (MHCC: 2014) reviewed relevant literature and conducted focus groups and online surveys with young people, mental health professionals and family supports in Australia, to explore the relevancy and utility of adult recovery concepts to young people and their families. The researchers concluded that while the five CHIME processes (Leamy et al., 2011) are relevant to young people, how these manifest differs according to a young person’s age and developmental stage. The authors also identified a number of challenges to implementing recovery oriented care in Australia:
flexibility and resource limitations; difficulty in facilitating empowerment of young people; and difficulties in transitions between service settings. They suggested that systemic change was needed to support recovery oriented practise in youth service including the need for better interagency collaboration, services to take a trauma informed approach and use of language used in adult recovery literature to be more youth friendly (MHCC, 2014).

While seeking out the perspectives of young people, their supports and mental health professionals offer a breadth of perspectives, eliciting responses to the existing CHIME domains and definitions does potentially limit the scope of the data gathered. Also in an Australian context, Ward (2014) utilised a developmental approach and existing literature to describe how the CHIME recovery framework may apply to young people. In particular, Ward points to research that suggests family (Collins & Laursen, 2004) and peers (Dishion & Tipsord, 2011) may play a more central role in youth recovery than for adults, emphasising the benefit of examining the external conditions of youth recovery. Drawing on the proposition that identity formation is a key developmental task (Kroger, 2006) he also suggests that diagnostic labelling may have a particularly powerful impact on a young person’s sense of self, especially in regards to personality disorders. He concluded by calling for more qualitative research to explore youth perspectives of recovery (Ward, 2014).

Ward’s (2014) proposition that young people’s recovery may be particularly impacted by identity development, and higher levels of dependence on their system of care, reflects a recurring theme in existing youth recovery literature (Rayner et al., 2018; Simonds et al., 2014; Ward, 2014). The impact of context on young people’s recovery journey was foregrounded Rayner and colleagues (2018), who (using narrative style interviews and grounded analysis) identified that young people’s personal recovery process was heavily influenced by their immediate personal environment, as well as wider systemic systems. They suggested that due to young people being much more reliant on their system or care–
both in regards to day-to-day life and their ability to successfully progress through developmental milestones—that youth recovery be conceptualised as an interactive process between person and the environment. Other youth research specifically focused on depression (Woodgate, 2006) and first episode psychosis (Romano et al., 2010) also emphasised contextual factors. Young people interviewed by Woodgate (2006) emphasised the explicit importance of flexible, consistent support from healthcare professionals in the process of recovery, while the importance of parents and other support was emphasised in the Romano and colleagues (2010) study.

The personal recovery process identified by Rayner and colleagues (2018) as sitting within this ecological environment, was highly consistent with the CHIME model (Leamy et al., 2011). Despite the foregrounding of the social constraints on young people’s lives, personal responsibility and self-management was still deemed relevant to youth recovery in this study (Rayner et al., 2018). In another study, young people with experiences of depression described being plagued with guilt and self-blame when experiencing setbacks in their mental health (Woodgate, 2006). The authors suggest that this finding reflects moral discourses about depression which encourage young people to feel personally responsible for their own success or failure in managing their mental health (Bennett et al., 2003). However, Simonds and colleagues (2014) interviewed young people and parents, and identified that those in the parent sample did not feel that young people should have to take responsibility for themselves and their difficulties. This difference may in part be explained by the young people in the latter study being aged between 14 and 16, compared to the sample in the Rayner and colleagues (2018) study which had a mean age of 20 years old.

Identity appears to play a central role youth recovery (J.E. Leavey, 2009; Rayner et al., 2018; Romano et al., 2010; Simonds et al., 2014). In the Simonds and colleagues study previously described, the three analytic themes identified related to an over-arching pattern
of loss and rediscovery of identity: *Loss of self; renegotiating the self,* and: *anticipating the future self* (Simonds et al., 2014). Similarly, young people interviewed by Leavey (2009) described being significantly impacted by stigma related to their experience and diagnosis, and subsequently feeling as though they lost their identity. Recovery was described as involving the re-establishment of social identity and being more accepting of themselves (J.E. Leavey, 2009). Likewise, *re-shaping an enduring sense of self* was identified as the key process underpinning young people’s recovery from first episode psychosis (Romano et al., 2010). Another study focusing on young people’s recovery from depression also highlighted young people’s emphasis on maintaining or renegotiating their identity (Woodgate, 2006). Similarly, studies focusing on what wellbeing means to young people with experiences of psychosis, have identified sense of self as important (Honey et al., 2015; Lal et al., 2014).

Young people have described recovery as a process concerned with holistic wellbeing. One study described this as a process of overcoming challenges associated with the loss of independence, friendships and academic functioning, as well as interruptions to career development and romantic relationships (J.E. Leavey, 2009). The process of moving from a place of disconnection and isolation, to connection has been highlighted as a key part of recovery (Rayner et al., 2018). Similarly, the importance of maintaining a sense of belonging with friends and family has been identified as important to young people living with depression (Woodgate, 2006).

Youth wellbeing literature has been useful to foreground the wider context of recovery. Young people diagnosed with a psychotic disorder described wellbeing as multi-dimensional, including psychological, physical, emotional, moral, material, spiritual and social dimensions (Lal et al., 2014). In a related paper (Lal et al., 2013) researchers outlined a range of activities that young people identified as integral to their wellbeing. A majority of
these activities fell outside the treatment setting, and included social activities like working and volunteering, as well as solo pursuits like journaling (Lal et al., 2013).

Similar to adult literature, existing youth research has identified that young people describe recovery as a journey or ongoing process (Bergmans et al., 2009; J. E. Leavey, 2009; Romano, 2010). Bergmans and colleagues (2009) identified that young people described “pockets of recovery” as well as “turning points” or notable moments that helped them become aware of choices, and understand and become more tolerant of emotions. These turning points had deep personal meaning, which the authors claimed were indicative of the highly personal nature of recovery processes (Bergmans et al., 2009). The recovery process has also been described as non-linear, dynamic and active, and characterised by a slow, gradual shift from despair, detachment and confusion toward greater awareness, wellbeing, agency and autonomy (Barnett & Lapsley, 2006; J. E. Leavey, 2009; Simonds et al., 2014). Agency has also been highlighted as important aspect of youth wellbeing more generally (Honey et al., 2015). Hope for the future, desire for personal change, and gaining meaning in life and from experiences, was also identified in these studies, which is also consistent with adult recovery literature (Leamy et al., 2011).

Overall, existing literature suggests that while many of the personal recovery processes and themes described in the adult literate apply to youth population, young people also face some particular challenges, in part due to unique developmental concerns and limitations. It has been argued that young people’s recovery process is more impacted by wider environmental factors included the system of care around them (Simonds et al., 2014; Rayner et al., 2018) and other work has emphasised the role of mental health services in youth recovery (Barnett & Lapsley, 2006; J. E. Leavey, 2009; Romano et al., 2010; Woodgate, 2006). However, a number of factors have also been identified as hindering the implementation of recovery-oriented youth mental health services (MHCC, 2014). Therefore,
eliciting the perspective of young people who have engaged with services may be an important part of finding out what works and what doesn’t for young people, and ultimately improving service provision (McGorry et al., 2013). The following section outlines the existing qualitative research on youth perspectives on their experiences with mental health services and interventions.

**Youth perspectives on service use and intervention experience.**

While existing literature suggests that young people see recovery as a personal journey, their engagement with formal mental health support appears to be an important part of this process. A review of papers exploring youth perspectives on mental health and mental health services has identified that young people tend to emphasise relational aspects of their care; describe issues with service accessibility and environment; and strongly value agency and choice in their treatment (Lavis & Hewson, 2011). These themes are consistent with another review that focused on youth perspectives on interactions with healthcare professionals and services more generally (Freake, Barley, & Kent, 2007). The following section outlines findings from existing literature in regards to what young people value and find challenging in regards to their experiences with professional mental health support.

It is important to note, that existing research indicates that young people tend to prefer calling on informal networks of family and friends for support with emotional and psychological issues, rather than engaging with professionals (De Leo & Heller, 2004; G. Leavey et al., 2011; Nada-Raja, Morrison, & Skegg, 2003). Lack of knowledge and fear of stigma have been described by young people as particular barriers to seeking professional help (Anderson, Fuhrer, & Malla, 2013; Lavis & Hewson, 2011), although having the support of a significant other person (caregiver, older friend) has been identified as helping to facilitate the help seeking process (Anderson et al., 2013; Prior, 2012). In regards to primary care, studies in the UK and Australia have identified that young people do not view
GPs as an appropriate source of help for psychological disorders or emotional distress. Young people described GPs as primarily focused on and being trained in physical health, and also as being too judgemental and close to their parents to make them appropriate forms of support (Biddle et al., 2006; G. Leavey et al., 2011).

However, research also suggests that young people who do want to engage with professional help, find it difficult to access services and challenging to navigate the mental health system overall (Summerhurst, Wammes, Wrath, & Osuch, 2017). Lack of timely access to appropriate treatment has been identified as a significant barrier to mental health recovery (Lavis & Hewson, 2011; Summerhurst et al., 2017; Buston, 2002; Houle et al, 2013; McCann & Lubman 2012). Authors of a qualitative New Zealand study described in the previous section (Barnett & Lapsely, 2006) argued that the young people in their study appeared to have been forced into crisis due to a lack of specialised non-acute services available to them. Another recent study identified accessibility as a key issues, with young people describing practical issues, such as appointments being made during school hours, and clinicians running late or cancelling sessions, as making engagement more difficult (Persson, Hagquist, Michelson, 2017). Concerns about having to rely on parents or public transport to get to appointments were identified as well, especially for young people who didn’t live close to service providers. In a New Zealand context, Gibson and colleagues (2016) reported that young people described wanting services to fit around their lifestyle and needs. Text and telephone services were described as meeting this need better than face-to-face therapy, and young people highly valued getting support in real time.

Existing research has also offered insight into young people’s views on both the physical and more intangible aspects of the service environment. In regards to outpatient settings, young people describe a preference for clinics to be informal, personalised and to feel less “institutional” (Persson et al., 2017). They also describe friendly staff members as
helping them to feel more welcome in a setting. In general, young people describe having negative experiences during stays at inpatient facilities (Barnett & Lapsley, 2006; Buston, 2002).

However, youth perspective research has consistently highlighted that young people emphasise the importance of the relational aspects of care over physical setting or specific interventions (Biering, 2010; Buston, 2002; Garland & Besinger, 1996; Gibson, Cartwright, Kerrisk, Campbell & Seymour, 2016; Lavis & Hewson, 2011; Persson et al., 2017; Lingreen et al., 2014). Young people have emphasised the importance of feeling understood, believed and respected and listened to (Buston, 2002; Gibson et al., 2016). Research also indicates that young people want to feel clinicians are genuinely interested in them as a whole person, and appreciate a sense of equality and mutuality in these relationships (Gibson et al., 2016; Persson et al., 2017). Disclosing personal information has been consistently described as challenging. Young people have described needing time and space to work towards this (Hartzell, Seikkula, & von Knorring, 2009; Lavis & Hewson, 2011; Lindgren, Siderberg & Skar, 2014; Persson, et al., 2017) and that having an approachable clinicians makes this easier (Buston, 2002). In one study, young people described “testing out” their therapist and using partial disclosure to assess how the therapist reacts to such information (Prior, 2012).

Related to this emphasis on relational aspects of care, is the finding that young people often identify continuity of care as being particularly important to them (Buston, 2002; Harper, Dickson & Bramwell, 2014; Lavis & Hewson, 2011). In one recent study, young people described early termination of therapy relationships as broken attachments, and also described retelling their problems to multiple people as traumatic and anxiety provoking (Harper et al., 2014). Similarly, in one study that explored young people’s experiences of transition from a CAMHS to a general adult service, young people described it being difficult having to leave behind the secure relationships they had built with their clinicians at
the CAMHS (Lindgren et al., 2014). Conversely, research suggests that having to change
doctors can be experienced as a positive if the relationship with the original clinician was not
valued or helpful (Buston, 2002). Continuity of care is hard to maintain in a service
environment demarcated by biological age and affected by high staff turn-over (Lindgren et
al., 2014; Lavis & Hewson, 2011).

Alongside this emphasis on relational aspects of care, research has also provided
insight into the types of interventions young people find most helpful. Talk therapy and
medication are two commonly discussed interventions. In one recent study, young service
users of a first episode mood and anxiety service, most commonly reported that “talking” and
“therapy” were the most helpful aspect of their treatment (Summerhurst et al., 2017).
Similarly, other studies have identified that “getting things out” and feeling listened to is
particularly important for young people (Gibson et al., 2016; Lynass, Pykhtina, & Cooper,
2012). It has been suggested that the opportunity to talk openly and freely in therapeutic
settings appears to be more important than problem-solving for young people compared to
adults (Dunne et al., 2000). However, other research has suggested that for some young
people, provision of information, concrete advice and problem solving are most highly
valued (Buston, 2002; Day, Carey, & Surgenor, 2006; Garland & Besinger 1996; Lavis &
Hewson, 2011; McCann & Lubman, 2012; Persson et al., 2017).

Young people have described finding the “right” therapist as an important part of
recovery (J. E. Leavey, 2009), and some youth researchers have focused more specifically on
the therapeutic relationship. Binder and colleagues (2011) used qualitative methods to
explore young people’s (aged 14–19) preferences in regards to the therapeutic alliance. They
identified that young people valued space for their autonomy respected and strengthened in
therapy, and also wanted to feel a genuine connection with their therapist (Binder, Moltu,
Hummelsund, Sagen, & Holgersen, 2011). In a similar study conducted with adult service
users, the need for space in the therapeutic relationship was not explicitly expressed so often (Binder, Holgersen & Nielson, 2010).

Medication has also been commonly discussed in existing youth perspectives research. In some studies, young people describe medication as an extremely positive aspect of treatment and as vital to recovery, although finding the “right” medication has been cited as a challenging process (J.E. Leavey, 2009; Summerhurst et al., 2017). However young people in other studies have described feeling stigmatised when taking psychiatric medication (Bluhm, Covin, Chow, Wrath, & Osuch, 2014) and also disappointed that medication was the primary or only intervention offered to them (Buston, 2002). Young people in the Buston (2002) study expressed a desire for more holistic treatment options to be made available.

Agency and choice have been consistently identified as salient themes when young people describe their experiences with services and interventions. Young people have described the importance of feeling as though engaging in treatment is their choice, and that appointments felt less helpful if they were pressured or forced to go to them (Gibson et al., 2016; Persson et al., 2017; Prior, 2012). This fits with suggestions that intrinsic motivation is associated with better clinical outcomes (Ryan and Deci, 2008). A New Zealand study that focused specifically on agency in counselling relationships identified that while young people positioned themselves as highly active agents, they also had an awareness of potential threats to their agency (Gibson & Cartwright, 2013). Their narratives also suggested that there were significant limitations on the amount of real power they had in the therapeutic relationship, and there was little evidence of them overtly resisting or challenging their counsellors. Young people have also described placing significant value on having choices about the involvement of their parents (Gibson et al., 2016; Harper et al., 2014). Concerns about having to have parents included in sessions, and in particular how they might react to
sensitive disclosures, have been raised in a number of studies (Day et al., 2006; Gibson et al., 2016; Persson et al., 2017; Strickland-Clark, Campbell & Dallos, 2000).

Another related common theme is the relevance of age in treatment. Young people have described the importance of not being “treated like a child” and having their problems taken seriously (Buston, 2002). Conversely, young people in a New Zealand study also described distressing experiences related to using adult inpatient services (Barnett & Lapsely, 2006). Harper and colleagues (2014) spoke to young people about their experiences in a new service for 16–19 year olds in the United Kingdom. All of the young people interviewed spoke positively about the collaborative approach their therapists took and described feeling as though the staff were more specialised and competent to work with people their age. The participants also described feeling less like they were treated like a child at this service (Harper et al., 2014). Interestingly, all of the young people interviewed felt that services should be based on developmental needs, rather than strict age band. Young people in this study also described feeling as though their own development had impacted their engagement, describing that they were better able to express themselves at ages 16–19, than they had been when engaging with services at a younger age.

Taken together, the findings of these studies highlight the diversity of young people’s experience and preferences. Overall, young people seem to place significant emphasis on the relational aspects of care but also value specific interventions such as therapy and medication. Within this, there appears to be variation in terms of the specific aspects of therapy young people appreciate, with some emphasising the benefit of having a safe place to talk through and understand their experiences while others appear to value more concrete, problem-solving approaches. The desire to have some agency and control over their treatment has been highlighted in a number of studies, although young people have also described experiencing limitations in their ability to successfully do this.
The Current Study in Context

This chapter has argued that the mental health of young people in contemporary New Zealand is a topical issue for good reason. New Zealand has high rates of youth mental health difficulties and suicide rates (Ministry of Social Development, 2016; Oakley Browne et al., 2006) and a mental health system that is under considerable strain (Allan, 2018; Elliott, 2017). Whilst research indicates that many young people prefer not to access professional help to support their recovery (De Leo & Heller, 2004; G. Leavey et al., 2011; Nada-Raja et al., 2003), some young people have also described considerable difficulty accessing help when they do want or need it (Barnett & Lapsley, 2006; Lavis & Hewson, 2011; Summerhurst et al., 2017). Also, the existing literature examining youth recovery has highlighted that environmental factors, including professional help, may be particularly relevant to young people (Rayner et al., 2018; Simonds et al., 2014; Ward, 2014). Whilst the dominant social discourses surrounding mental health and recovery emphasise empowerment, personal responsibility and self-management, there is a significant body of knowledge that indicates that mental health issues are influenced by a number of social determinants (Kake et al., 2008; Moffit et al., 2011; Read, 2004; Tinghög et al., 2007). Moreover, young people today are living in a rapidly changing environment characterised by an emphasis on personal responsibility and choice (Beck, 1992; Beck & Beck-Gernsheim, 2002; Schwartz, 2004) yet are still limited in how much real power they can exert due to legislation and social norms (France & Threadgold, 2016; France, 2007).

It is increasingly being recognised that young people can offer a valuable perspective on their own experiences (Morrow & Richards, 1996) but there is currently limited research exploring young people’s experiences of mental health difficulties and recovery. The little that is available suggests that while there may be overlap with adult recovery processes, young people may have different priorities for recovery than do adults (J. E. Leavey, 2009;
Rayner et al., 2018; Romano et al., 2010; Simonds et al., 2014). It is this gap in our collective knowledge that this research aims to address.

As the recovery paradigm privileges lived experience over clinical knowledge, and first person narratives have played a significant role in the development of the recovery concept (Brown, 2008; Deegan, 2002; Lapsley et al., 2002; Spector-Mersel & Knaifel, 2017; Thornhill et al., 2004) it makes sense to apply this method to explore young people’s experiences of mental health difficulties and recovery. This research aims to build on the small number of existing qualitative studies that have sought to understand youth recovery both in its own right, and in relation to models of recovery generated from adult perspectives. The social generation approach to this research, which views youth as a dynamic social process (Buckingham & Willett, 2006; White & Wyn, 2013; Woodman & Wyn, 2015), also allows for the acknowledgement that young people in contemporary New Zealand likely face a set of particular challenges compared to young people in other parts of the world, or at other points of time.

As such, this study has two main aims: to gain insight into how young people in present-day New Zealand make sense of their mental health difficulties and recovery, and, to explore how young people understand the role of mental health services in their recovery process. An overarching narrative methodology will be utilised to provide young people with an opportunity to talk about the aspects of their experiences they consider most relevant, and also to allow for the dual exploration of subjective and cultural meaning-making processes.
Chapter Three: Methodology

This research aimed to explore how young people look back and make sense of their personal experiences of mental health difficulties and recovery. Drawing on interviews with 12 participants who self-identified as having experiences of youth mental health difficulties, it was designed to gain insight into subjective meaning-making, as well as to explore how young people’s accounts relate to recovery themes identified in the existing literature. In addition, the interplay between participants’ personal narratives and dominant cultural narratives regarding mental health and youth were also examined. Whilst the epistemological and theoretical underpinnings, and method of data collection are primarily aligned with a narrative approach, both narrative and thematic analytic methods were used. The decision to use a two-pronged analytic approach was made in response to the identification of patterns and themes that cut across participants’ narratives that were extremely relevant to the research questions, yet not adequately captured by the narrative analysis that has a holistic focus. This flexible approach reflects the concept of “researcher-as-bricoleur” proposed by Nelson and colleagues (1992), which describes qualitative researchers creatively weaving together different methods to answer their particular research questions.

In this chapter I will begin by outlining the theoretical underpinnings of this research. Firstly, I will locate the current research in the context of qualitative research more generally, before describing the specific epistemological position upon which the study is grounded. I will then discuss the narrative theory that guides the research. Following this, I will outline the methods used to recruit young people to participate in the research, the interview and data collection process and the specific analytic approaches used. Considerations of research ethics and are also discussed. Of course, my own personal narrative and experiences have profoundly impacted this research, from my initial decision to focus on youth mental health, all the way through to the conclusions and recommendations made in the final chapter.
Reflexivity is at the core of the theoretical and epistemological underpinnings of this study, and I have attempted throughout this chapter to shine a light on some of the ways in which my own background and present day context has influenced the research process.

**Theoretical Framework**

Qualitative research seeks to understand meaning and to explore the different ways people make sense of their worlds and experiences (Braun & Clark, 2013). As such, qualitative researchers seek to foreground the contextual and the subjective, and explicitly situate research findings in their unique historical and cultural contexts (Creswell, 2009). Because qualitative research takes place in the “real world”, where events, people and their experiences are not controlled, it often involves unique and unexpected phenomena (Rohleder & Lyons, 2015). This demands a degree of flexibility and dynamism on behalf of the researcher.

Research in the field of psychology began by privileging subjective experience (Danziger, 1990) and qualitative research has made significant contributions to the field over the years (Kvale, 2003). However, during the first part of the 20th century, psychology was reconceptualised as a behavioural science and quantitative methods began to dominate, with other approaches being largely deemed unscientific (Danziger, 1990). Qualitative methods were relegated to the fringe of psychological science and positioned as “soft science” (Chamberlain, 2013; Willing & Stainton-Rogers, 2008). However in recent years, there has been somewhat of a shift back towards qualitative methods, in line with a wider “interpretive turn” in social sciences (Willig & Stainton-Rogers, 2008).

The concept of recovery developed out of the service user movement which explicitly aimed to offer a subjective, “lived experience” alternative to the “expert” medical clinical knowledge that had previously dominated mental health discourse. Therefore, recovery
literature is one area of mental health research that has been dominated by qualitative methods since its inception (Slade et al., 2012). Following in the tradition of recovery, the present research utilises a qualitative approach to understand how young people make sense of their personal experiences of mental health difficulties and recovery, while also illuminating the wider social and cultural context of their meaning-making process.

Qualitative research is an umbrella term that encompasses many different methodologies, theoretical positions and epistemological assumptions. It is therefore important to specify that this research is grounded in a critical realist epistemology. Critical realism emphasises the existence of “reality” whilst positing that the way we understand and perceive this reality is constructed. According to this approach, our conception of reality is considered distinct from reality per se (Alvesson & Skoldberg, 2009; Bhaskar, 1998) with the knowledge we “have” about reality being dependent on the questions we ask about it (Danermark, Ekström, Jakobsen, & Karlsson, 2002).

Taking a critical realist position allows for both the acknowledgment of the “real” suffering experienced by young people with mental health difficulties, as well as the influence of the wider social and cultural context on how this suffering is positioned and experienced. As Ussher (2010) points out, the complete dismissal of positivist, medical models of mental health (such as that taken by a social constructivist approach) can be considered to undermine the pain and distress that many people experience. Critical realism also acknowledges that the relationship between “reality” and social constructions of reality is complex, and that causality can exist on different levels (Bhaskar, 1998). Thus, critical realism facilitates the exploration of how the notion of “youth” and the position of young people in contemporary New Zealand, may not only influence how young people experience and understand their mental health difficulties, but may also contribute to the high rates of youth mental health problems seen in this country.
Critical realism is also underpinned by a desire to not only understand and explain the world, but also to try to change it (Alvesson & Skoldberg, 2009). This makes it an inherently good fit for youth service user perspective research. While the service-user movement has made significant gains in advocating for the rights of people with mental health difficulties, youth voices have been largely absent. This reflects the wider trend for young people to lack a voice and for their opinions about their own lives to be undervalued and not taken seriously (Prout, 2007). This research aimed to elevate and value young people’s stories and voices in a domain that has largely been dominated by adults, academics and practitioners. Within a broad critical realist approach, this study was primarily guided by narrative theory and utilised both narrative and thematic analytic methods to explore the data and its meaning.

**A narrative approach.**

Narrative research is proposed to offer a way to explore how people make sense of their world and experiences through story telling (Murray & Sools, 2015; Riessman, 2008). Ricoeur (1984) described narrative as a tool employed by people to bring order to experiences that would otherwise feel chaotic, while McAdams (1993) suggests we are “narrative beings” who construct our identities through storying our internal and external experiences into narrative form. Narrative research has enjoyed a surge in popularity in humanities and social science research over the previous three decades (Andrews, Squire, & Tamboukou, 2013) and it has been suggested that narrative approaches are particularly suited to exploring recovery from mental health issues (Kirkpatrick, 2008; Rhodes & De Jager, 2014). Spector-Mersel and Knaifel (2017) go so far as to propose that narrative and recovery are "sister paradigms" due to ontological and epistemological similarities (p. 4). They also point to the shared emphasis on meaning, identity, change, agency, holism, culture, uniqueness and context (Spector-Mersel & Knaifel, 2017).
As alluded to above, while eliciting narratives is considered to provide insight into a person’s inner world and their subjective meaning-making processes (Riessman, 2008), narrative researchers also often foreground the specific social and cultural context within which narratives are produced (Clandinin & Connelly, 2000; Riessman, 1993). Narrative construction has increasingly been thought of as both a psychological and social process that provides a window into the interplay between personal experience, social structures and meaning-making (Avdi & Georgaca, 2007). It is with this viewpoint that the present research is aligned. A narrative approach was considered a particularly suitable way to validate and respect the individual perspectives expressed by young people, while also acknowledging that their narratives may (in part) be constructed by accepting, combining and reworking existing narrative patterns made available to them through dominant cultural discourse (Elliott, 2005; Frank, 1997; Kirkpatrick, 2008).

Narrative patterns that exist in our cultural milieu have been referred to as “cultural stock stories” (Hänninen, 2004) which can be conceptualised as encompassing all the narrative representations a person is exposed to throughout their lives, through mediums ranging from gossip to literature to advertisements. Stock stories can be thought of as mediating the relationship between personal narratives and wider cultural discourses. McAdams and McLean (2013) refer to this concept as a culturally specific “menu” of images, themes and plots that people both perpetuate and modify through an active process of selection and appropriation that they engage in to develop personal stories that capture their own experiences.

Narrative theorists have highlighted the fact that various cultural stock stories or narratives differ in regards to their power or influence (Hänninen, 2004). Some are dominant and normative, while others provide counter or alternative narratives (Andrews, 2002). It has been argued that, while dominant narratives are not always negative, the narratives available
to people who are marginalised in some way, are often limiting, defined by others and negative in nature (Rappaport, 1995). This research is premised on the view that, while people have some personal agency to creatively select and manipulate stock stories for their own purposes, they are also somewhat constrained by cultural influences (Hänninen, 2004; McAdams & McLean, 2013). Research indicating that people often resist dominant negative narratives about themselves or their situation and actively seek out alternative narrative interpretations, may offer some support for this perspective (Hannenin, 1991; Kirkpatrick, 2008).

Narrative research that has focused on illness or other major life changes can be considered to foreground how autobiographical narratives can reflect cultural stock stories (Crossly, 2000; Frank 1997; Murray 2000). Ricoeur (1984) suggests that after a crisis or trauma, making narrative sense of the world is more difficult. Major life events disrupt the structures and shape of everyday life that are often taken for granted, forcing a conscious reformulation of narrative. Some narrative researchers have suggested that the way people reformulate their life narrative after significant “negative” life events, is associated with their ability to adapt to challenging life circumstances (McAdams, 2006; McAdams & McLean, 2013; McAdams, Reynolds, Lewis, Patten & Bowman, 2001).

McAdams and colleagues suggest that the ability to make meaning out of negative situations or emotions, is linked to positive adjustment and psychological well-being (McAdams et al, 2001; McAdams & McLean, 2013). They describe “redemption” sequences (McAdams, 2006) as marking the transition from the description of an emotionally negative situation or phenomenon to an emotionally positive outcome. This often entails a process of meaning-making—such as learning something about the self or the world—or the development of a positive situation that is positioned as not being able to occur without the preceding negative experience.
Pals (2006) suggests that people who describe themselves or their lives as ultimately being enhanced or strengthened by negative events often engage in a two stage process of firstly reflecting on the experience, and then committing to a positive resolution of the event. It is proposed that the first step is associated with personal growth and the second stage with happiness. Research with both adults and youth samples, suggests that narratives characterised by positive resolution to negative experiences are associated with higher levels of subjective well-being and happiness (Lilgendahl & McAdams, 2011; Tavernier & Willoughby, 2012).

As identity has been suggested to be of particular relevance to both youth and recovery (Baumeister & Muraven, 1996; Erikson, 1963, 1968; Leamy et al., 2011; Rayner et al., 2018), using a narrative approach was deemed particularly appropriate for this study. The idea that constructing stories is vital to the development and maintenance of identity has gained momentum over recent years (McAdams & McLean 2013). The concept of narrative identity (McAdams, 1993; McAdams, Josselson, & Lieblich, 2006; Mclean, Pasupathi, & Pals, 2007; Singer, 2004) describes the development of an internalised, evolving life story that creates a coherent account of identity over time (McAdams and McLean, 2013). Narrative identity is proposed as having two psychological functions: providing a sense of purpose and meaning and; providing a sense of unity across time and situations.

It has been suggested that narrative identity emerges during late adolescence and early adulthood. Building on Erikson’s (1963) model of psychosocial development, McAdams (1985) suggests that development of narrative identity helps to resolve questions such as “who am I?” and “where is my life going?” Like Erikson, McAdams and colleagues link the development of narrative identity to both cognitive development and social expectations (McAdams, 1985; McAdams & Mclean, 2013). Narrative coherence has been described as an important aspect of developing a meaningful sense of identity (Pals, 2006), although
coherence is described as an ongoing, iterative task because an individual’s “life story” is dynamic and always changing (McAdams, 2001).

**Approach to youth research**

Knowledge generated by first-person recovery narratives has played a significant role in the development of the concept of personal recovery, which in turn has impacted on mental health service provision (Roe & Davidson 2005; Rhodes & de Jager 2014; Kirkpatrick 2008). The present research follows in the tradition of using narratives as a mode of resistance to existing power structures (Andrews, Squire, & Tamboukou, 2013). More specifically, this research aims to elevate the voice of young people in the field of mental health that has traditionally been dominated by “expert voices” of clinicians, academics and policy makers. It also aims to promote young peoples’ subjective, human interpretations of wellness and recovery, in a mental health system that adheres to a recovery paradigm based on adult perspectives. By using the unstructured interview style typical of narrative research, participants were provided with an opportunity to construct their own stories and to use their own voice with minimal guidance by myself as researcher.

As discussed in the previous chapter, despite youth being revered in late-modern societies like New Zealand, young people’s lives are heavily influenced and shaped by policy frameworks that they have little or no influence over (France, 2007; France & Threadgold, 2016; White & Wyn, 2004). In New Zealand, this situation somewhat contradictorily sits within the context of economic and social reform that has seen a shift in youth policy away from a welfare approach towards self-responsibility (Wyn & Harris, 2004). As a result, young people in contemporary New Zealand live in a context that values and encourages self-responsibility, yet also face structural and social limitations on how much agency they can exert over their own lives. It has been suggested that this combination of factors, along
with other rapid social and technological changes, pose a particular set of challenges for contemporary young people. Researchers who conceptualise “youth” as a social process, strongly emphasise the importance of not assuming that youth experiences of past generations are normative for contemporary young people, and thus call for research frameworks that explore how young people today are shaping their lives and futures for themselves (Dwyer and Wyn, 2004). The present research draws on a social generation approach to youth research that foregrounds the impact of contemporary society on young people’s experiences.

**Researcher reflexivity**

Qualitative methodologies assume that research is a subjective process and that researcher influence is inevitable (Braun & Clarke, 2013). Everything from a researcher’s age and gender, to their socio-economic status, life experiences and personality will influence a project from conception to completion. Unlike quantitative paradigms which tend to promote the control and eradication of researcher influence, qualitative methods embrace researcher subjectivity as a tool. It has been suggested that the key to harnessing this tool is to actively consider, acknowledge and critique researcher subjectivity through an ongoing process of reflexivity (Braun & Clarke, 2013). Narrative research also assumes that the researcher plays a participatory role, not only research design and analysis, but also in the production of the narratives themselves (Elliot, 2005). Therefore, reflexivity requires much more than just reflection on decision making processes and paradigm assumptions. It also involves on-going project critique and the researcher to foreground their own moral, social and political stance (Koch & Harrington, 1998).

This research project was inspired and influenced by both my personal experiences and interests, as well as my professional and academic preferences. I experienced mental
health difficulties as a young person, which I believe influenced my interest in this topic and likely also my decision to pursue clinical psychology as a profession. Prior to embarking on this project I had reflected many times on how my experiences had influenced my sense of self, how I saw my place in the world, and how those experiences may impact my future. The way I have conceptualised these experiences has been fluid—changing not only over different periods of my life, but also depending on the context I am in. During my clinical psychology training I became aware that despite the large numbers of young people experiencing psychological distress in this country (Oakley Browne et al., 2006), there was a lack of research investigating young people’s own perspectives on their experiences. This struck me as an important gap, especially considering the increasing attention this topic has received in public discourse.

In line with the activist traditions of both a critical-realist position and narrative methodology, it is hoped that this research will add volume and diversity to the current youth mental health stock stories available to young New Zealanders. These epistemological and methodological choices are also undoubtedly products of my personal and academic experiences. Spending some of my formative years growing up in a relatively liberal, academic community during South Africa’s transition from apartheid has likely influenced my tendency to question the status quo, rather than taking convention and custom at face value. My undergraduate experience as a cultural studies and political science student also instilled an interest in how language and stories can both reflect and shape knowledge and power structures, and also how invisible systemic factors can influence the subjective experiences of individuals.

My professional interest in working with young people also contributed to my decision to pursue this research topic. At the outset, I hoped that, through having the opportunity to talk to young people about their experiences, I might develop a more nuanced
perspective on youth mental health that may ultimately improve my future clinical practise. As the project neared completion, I began practising as an intern psychologist in a clinical setting focused on youth. This undoubtedly also had an impact on the way I interacted with the data and interpreted the findings of the analytic process.

Power dynamics between researcher and participant are inevitably skewed and quite likely influenced the narratives created in this project in a number of ways. The fact that I was close in age to some of the participants may have reduced potential power differentials in comparison to an alternative situation where I interviewed young people under the age of 18. My personal experiences of mental health difficulties as a young person, which participants were made aware of (in brief), may have offered a point of commonality or connection with some participants in the study, but may have felt problematic or uncomfortable for others. The fact that participants knew I was training to be a clinical psychologist may have added another layer of complexity, especially considering that young people described having very mixed experiences with psychologists. In addition, research has indicated that members of the peer workforce report experiencing stigma and discrimination in their workplaces (Scott et al., 2011). Through the clinical training and work experience I undertook in parallel with the development of this project, I encountered divergent opinions regarding the usefulness and appropriateness of peer involvement in mental health service provision: while some clinicians appeared to highly value the expertise peers could bring to services, others appeared resistant to their place in mainstream mental health services. Therefore, for some of the young people I interviewed, discussing their stories with someone working towards becoming a “clinician” may have impacted what and how they chose to share what they did.

In the forward to Cohen’s *Mental Health User Narratives* (2015), Jeffrey Moussaieff Masson proposes that Cohen, as a sociologist, has less of a vested interest in framing service
user narratives through the lens of “mental illness” than someone working in mental health. I am sympathetic to his point and acknowledge that my clinical training undoubtedly coloured my approach to the research and interpretation during the analytic process. However there are many within the field of clinical psychology who are extremely critical of dominant narratives of mental health and also feel marginalised in a system that seems to be dominated by the biomedical model and demand for brief interventions. However, Moussaieff Mason’s comments do perhaps reflect a wider mistrust of those in the field of clinical psychology that exists in the peer and service user community, and it was important for me to be aware of this during the research process.

Method

This research was approved by the University of Auckland Human Participant Ethics Committee in December 2015 (Reference 016449). All relevant documents, including consent forms, participant information sheets and the interview guide can be found in the appendices of this document. The following section outlines the research methods used in the study.

Participant recruitment.

To answer the research questions outlined in the previous chapter, I wanted to talk specifically to people who had self-identified as having personal experience of youth mental health difficulties, but who at the time of the interview considered themselves some way along the process of recovery. Because this research was interested in how people reflect on and make sense of their experiences, I was not looking to interview young people who were in the midst of being acutely unwell. While the perspectives of people who are acutely
unwell are of course as valuable and important as any other, this was not the focus of the present research.

Accessing a group of people who shared an experience in the past, but not necessarily anything in the present day, posed a significant recruitment challenge. I also hoped to include young people with more significant experiences of mental distress than those commonly represented in existing New Zealand research (Gibson & Cartwright, 2013; Gibson & Cartwright, 2014). Around the time that I was grappling with this issue, I started coming into contact with the peer workforce. It occurred to me that young people working in these roles may offer a particular, yet extremely valuable range of perspectives. So while a sample of young peer support workers and consumer advisors could be considered a sample of convenience, it was an under-utilised one that would likely represent a varied range of experiences. I had some extremely helpful conversations with people working in the peer and consumer space, which also encouraged me. As a result, this research specifically targeted young members of the peer workforce, who self-identified as having experienced mental health difficulties as a young person and who at the time of the interview, felt they were some way along the process of recovery.

Participants were primarily recruited through mental health non-governmental organisations (NGOs). I gave a short presentation on the proposed research at a number of these organisations, providing information about the purpose, aims and ethos of the project, as well as other information related to confidentiality, consent and required time commitment. Presentation attendees had the opportunity to ask any questions and, at the end of each presentation, participant information sheets were left behind and people were invited to contact me to express interest in participating. The study was also advertised by displaying posters at participating organisations, distributing email advertisements to peer and consumer networks, and via the Facebook pages of participating organisations.
Once young people made contact to express interest in the study, I called them to talk through the finer details of the research and to ask some brief screening questions to ensure they met the inclusion criteria for the study. This criteria included: being aged between 18–30 years old at time of phone call; currently working in the New Zealand mental health peer workforce; not currently using acute mental health services or self-identifying as being actively unwell and being available to be interviewed in person or via Skype. Potential participants were neither included nor excluded on the basis of the specific diagnoses or the “type” of mental health issues they experienced. If they agreed to participate, a time and venue was arranged to conduct the initial face-to-face interview and participants were provided with a copy of the participant information sheet and consent form. All participation in this study was voluntary.

Despite the generosity and support of many members of the peer workforce and mental health NGOs more generally, recruiting young people to talk about their experiences was challenging. Many members of the peer workforce who were in their mid to late 30s (and older) expressed interest in participating. However, in light of my social generational approach, which emphasises the relevance of social context (White & Wyn, 2013; Woodman & Wyn, 2015), I felt it was important to restrict the age limit to those who had more recent experiences of youth mental health difficulties. As a result, the number of people who volunteered to participate was appropriate for the research methodology, but no young people were excluded from the study on the basis of exceeding sample size. There was one young person who initially agreed to take part, but then decided to withdraw before the interview due to a change in life circumstances.

Participants.

The sample consisted of 12 young people aged between 18–27 years old (M = 23), who identified as having personal experiences of mental health difficulties and at the time of
data collection, were employed by either a mental health NGO or DHB. Seven participants identified as female, four as male and one as non-binary. The participants came from a wide range of ethnic backgrounds: five identified as Pākehā or New Zealand European, one as New Zealand Māori/New Zealand European, one as European/New Zealand European, one as Fijian Indian/New Zealand European, one as Samoan/Tongan, one as Fijian Indian, one as Indian and one as South African. Nine of the participants were living in Auckland, one in Dunedin, one in Christchurch and one in Wellington. Some participants also described living and using services in other places in New Zealand including Taupo, Wanganui, Westport, Nelson, Whitianga, as well as in South Africa.

Many of the young people described being given a range of mental health diagnoses during their engagement with mental health services, despite neither a diagnosis or service use being a requirement for participation. Diagnoses included (but was not limited to) depression, anxiety, bi-polar, borderline personality disorder and schizophrenia. Many young people had been given multiple diagnoses at different points of their journey. All of these diagnoses warranted engagement with formal mental health service providers and all bar two participants utilised public mental health services. However, not all young people identified as having significant mental health conditions or saw their diagnoses as an accurate or sufficient account of their experiences. In keeping with the person centred approach to their research I have prioritised participants’ own representations of their difficulties, rather than objective diagnoses.

Throughout this research, the terms mental health difficulties, mental health problems and mental health issues have been used somewhat interchangeably. During the interview process, young people also often used the terms “unwell”, “un-wellness” and “distress” when describing their experiences, so these terms have also been incorporated into the work. The terms “mental illness” and “mental disorder” have only been used when quoting an existing
study or a participants’ own words, or in the context of describing a diagnosed mental health disorder.

**Table 1 Participant Demographic Characteristics (n = 12).**

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Identified gender</th>
<th>Identified ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jayita</td>
<td>24</td>
<td>Female</td>
<td>Fijian Indian and Pākehā/New Zealand European</td>
</tr>
<tr>
<td>Charlotte</td>
<td>27</td>
<td>Female</td>
<td>Pākehā/New Zealand European</td>
</tr>
<tr>
<td>Chris</td>
<td>24</td>
<td>Male</td>
<td>Pākehā/New Zealand European</td>
</tr>
<tr>
<td>Lucy</td>
<td>25</td>
<td>Female</td>
<td>South African</td>
</tr>
<tr>
<td>Faye</td>
<td>25</td>
<td>Female</td>
<td>European and Pākehā/New Zealand European</td>
</tr>
<tr>
<td>Kalena</td>
<td>25</td>
<td>Female</td>
<td>New Zealand Māori and Pākehā/New Zealand European</td>
</tr>
<tr>
<td>Vijay</td>
<td>21</td>
<td>Male</td>
<td>Fijian Indian</td>
</tr>
<tr>
<td>Isieli</td>
<td>23</td>
<td>Male</td>
<td>Samoan/Tongan</td>
</tr>
<tr>
<td>Jared</td>
<td>22</td>
<td>Male</td>
<td>Pākehā/New Zealand European</td>
</tr>
<tr>
<td>Aasha</td>
<td>22</td>
<td>Female</td>
<td>Indian</td>
</tr>
<tr>
<td>Sarah</td>
<td>22</td>
<td>Female</td>
<td>Pākehā/New Zealand European</td>
</tr>
<tr>
<td>Sam</td>
<td>18</td>
<td>Non-binary</td>
<td>Pākehā/New Zealand European</td>
</tr>
</tbody>
</table>

*All names have been changed to maintain confidentiality*

At the time of the interview, all of the participants were working in mental health, including in peer support (n = 6), consumer advisor (n = 3) and service-user development (n = 1) roles. One young person interviewed was working as a mental health community support worker (CSW), but had been eligible for this role due to their peer support training. Another participant was primarily employed as a counsellor; however they had worked in multiple peer roles just prior to taking part in the research. A majority of the young people in
this study had completed some form of peer training: three had completed Wellness Recovery Action Plan (WRAP) training, three had completed Peer Employment Training (PET) and two had International Peer Support (IPS) training. None of the three young people working in consumer advisor roles had completed peer training; however all of them were currently studying at University at the time of the interview. In total, six of the young people had either completed a University Bachelor’s degree or were in the process of doing so at the time of the interview. Four of the young people had completed their Mental Health and Addictions Level 4 training.

**Data collection.**

A narrative interview approach was utilised to obtain qualitative data (Murray 2000; Riessman, 2008) and the interview style was characterised by open questions and a conversational style to elicit rich, in-depth data. The face-to-face interviews took between 60 and 90 minutes and were held at a location and time convenient to the participant. Interviews were digitally recorded and then transcribed verbatim by one of two professional transcribers, both of whom had signed confidentiality agreements and were approved by the University of Auckland. Participants were contacted approximately one week after the initial interview to provide them with an opportunity to reflect on the interview process and discuss any further insights they may have had since. This was consistent with narrative approaches that see the value in participants’ reflections on the interview process (Squire, 2008). Eleven participants were able to be successfully contacted for a follow-up phone call.

At the start of each interview, I introduced myself and spent some time building rapport with the participant. As context is thought to have direct influence on the construction of a narrative (Mishler, 1986), I worked hard to foster a relaxed, conversational environment in the initial stages of the interview. The purpose and aims of the study were discussed again, including researcher motivation. This was not only an ethical requirement,
but also likely influenced the narratives produced. Research focusing on young people shows that the context of a conversation has important implications for meaning-making processes (McAdams & McLean, 2013). For example, it has been shown that meaning appears more important and relevant in narratives produced in the context of explaining oneself, rather than in the context of entertaining someone (McLean, 2005). Participants were also provided with another copy of the participant information sheet and invited to ask any further questions. Confidentiality and its limits were explained and participants were required to sign a consent form before the formal interview began.

I began the recorded interview by reminding each participant about the aims of the research and inviting them to talk about their experiences, encouraging them to begin their story from wherever they felt made sense. With some participants, this opening statement elicited a response that lasted between 10 and 20 minutes. During this time, I worked hard to demonstrate active listening by using minimal encouragers such as “mmm” and non-verbal signs of attention such as nodding, behaviour which has been shown to elicit narratives that are more elaborate (Pasupathi & Hoyt, 2010). As is typical in narrative interviews, it was only after the participant appeared to have reached the end of this initial narrative response that I directed them back to specific parts of their story to elicit further information (Rosenthal, 1993; Wengraf, 2013).

Participants began their stories at quite different points—some provided a description of what they were like as a young child, while others described their circumstances immediately before their difficulties began. I often asked them to provide a bit more detail about the starting point of their story, such as “You mentioned you were an anxious child, perhaps you could tell me a bit more about that?” I also went back to other topics that felt important, for example if someone mentioned using services, I would go back and ask them to elaborate in more detail on this aspect of their story, inquiring about what was
helpful/unhelpful about that experience, or how they understood their interactions with a specific clinician in the present day. For young people whose story did not lead into talking about recovery, questions such as “how do you make sense of where you are today?” and “can you tell how you got from the difficulties you were experiencing at that time, to where you are today?” were asked to elicit information about this aspect of their experience. Some participants appeared to require more prompting during the initial stage of the interview. In these cases a more directive approach was taken and I utilised questions such as “and what happened then?” or “can you tell me a bit more about what was happening at that time?” While this likely resulted in the interview being more co-authored, for some young people this was the only pragmatic way to elicit their story.

Analysis.

Researchers who employ an overall “narrative approach” may choose to use analytic methodologies that are not strictly considered narrative—such as grounded theory or thematic analysis. While Spector-Mersel & Knaifel (2017) argue that taking a holistic approach and interpreting accounts as a whole unit (Lieblich et al., 1998; Spector-Mersel, 2014) is fundamental to narrative research, others have suggested that qualitative researchers should be innovative and flexible in their approach and consider weaving together different analytic methods to best address research questions (Chamberlain & Murray, 2008; Nelson, Treichler & Grossberg, 1992). Utilising multiple analytic methods has been suggested to facilitate a more holistic understanding of complex phenomena (Brannen, 2005; Floersch, Longhofer, Kranke, & Townsend, 2010) and integrating narrative and thematic analytic methods has been used in research focused on young people before (Shukla, Wilson, & Boddy, 2014).

I utilised a narrative analysis to gain insight into how young people make sense of their experiences of mental health difficulties and recovery, and to foreground the interplay between subjective and cultural meaning-making processes. In line with Lieblich and
colleagues (1998) and Spector-Mersel (2014), the narrative analysis was focused on interpreting and comparing participants’ stories as a whole.

While undertaking the narrative analysis, commonalities and differences were identified across participants’ accounts, particularly in relation to their interactions with the mental health system. These patterns were considered relevant to the research question and not adequately captured by the narrative analysis which was more focused on particularity and specificity of narratives forms as a whole. A thematic analysis was identified as providing a useful adjunct to this and was used to deepen insight into young people’s experiences with services and professionals, by exploring themes and patterns of meaning across young people’s stories. The thematic analysis allowed me to target more specific questions about the way participants understood their experiences with services and professionals in relation to their recovery. This method also enabled the identification of common commonalities in the experiences of participants.

**Narrative analysis.**

As I was interested on how young people made sense of their personal experiences of mental health difficulties and recovery, this research could be considered to take a “big story”, experience-centred approach to narrative analysis (Andrews et al., 2013; Bury, 1982; Patterson, 2013; Ricoeur, 1984, 1991). Experience-centred approaches are premised on the idea that narratives are sequential and meaningful and often describe a process of change or transformation (Squire, 2013). Interview transcripts were analysed using a holistic interpretive approach, which considered both the content and form of the stories as a whole unit (Kohler-Riessman, 2000; Lieblich et al., 1998; Murray, 2003; Riessman, 2008; Spector-Mersel, 2014). Crossley (2007) laid out a number of sequential analytic steps which guided the analytic process: reading and familiarising self with transcripts; identifying important
concepts including tone, imagery and themes (McAdams, 1993); weaving these images and themes into a coherent story; and writing up into a report.

As suggested above, the first step involved reading and re-reading interview transcripts. To help consolidate how I had made sense of the overall plot of the story, I made notes in the margins and wrote up very brief summaries of each participants’ account. Following this, each individual narrative was re-read through the specific lens of narrative tone, imagery and themes. As suggested by Murray (2003), while particular themes were identified within the narratives, these were located within the narrative framework as a whole, rather than across all participants’ accounts, as might be done in a thematic analysis (Braun & Clarke, 2006). In keeping with both the methodological underpinnings and the recovery focus of the research, attention was also paid to how the young people narrated transformation of identity and agency over time (Spector-Mersel & Knaifel, 2017).

Once individual accounts were analysed, they were compared to each other in order to identify similarities and differences between them. Through an iterative process, patterns in form and content within narratives as a whole were slowly identified. Different recovery narrative “types” or “kinds” were identified, an interpretive strategy first employed by Frank (1995) and subsequently other narrative researchers such as Crossley (2000) and Hänninen and Koski-Jäennes (1999). It was identified that the narrative types appeared largely influenced by the way the young person conceptualised the cause of their mental distress. Jacobson’s (2001) dimensional analysis of recovery narratives proved a useful resource when considering these narrative types, and helped to clarify the link between the causal explanation provided in young people’s accounts and the subsequent “recovery tasks” that followed. The causal explanation provided was also identified as being linked to the way in which young people described key recovery themes of agency and identity (Leamy, 2011; Davidson et al., 2005).
In order to foreground the social context of these personal narratives, a strategy borrowed from Hänninen and Koski-Jäennes (1999) was utilised. This involved reading each story and identifying cultural stories that were influencing each account, the causal explanation provided for mental health difficulties, the “cure” or “recovery” tasks the young person prescribed themselves and also their “moral assessment” of their experiences. Moral assessment was used in a relatively loose way, focusing on who or what young people “blamed” for their experiences. In addition, attention was also paid to how I might have influenced the construction of the participants’ narratives and possible constraints this may have imposed.

Once preliminary narrative types were decided upon, these were discussed with my research supervisor as a way to unpack some of the complexities and ambiguities in the data (Hill et al., 2005). While most of the stories clearly aligned with one of the narrative types, there was one young person’s account in particular that was more difficult to make sense of. Discussing this with my supervisor proved a useful exercise and helped to identify that the young person’s account did in fact share many of characteristics of one of the narrative types. Once the narratives types were finalised, an “exemplar” story was selected and written up, to illustrate the key narrative theme, tone and other defining characteristics. Following the development of an exemplar story, further analysis was provided linking the exemplar story to other accounts included in the narrative type. A particular challenge in relation to both the exemplar story and the additional analysis was striking a balance between providing adequate detail to give a rich enough account versus providing so much detail that story and analysis distracted from the core essence of each narrative type. Once again, discussions with my research supervisor and an iterative process of re-working this section, proved helpful in achieving this balance.
Thematic analysis.

Thematic analysis is concerned with identifying patterns of meaning and themes across participants’ accounts (Boyatzis, 1998; Braun & Clarke, 2006: 2013). The thematic analysis was focused on exploring how participants described the role of professional support in their recovery process. The thematic analysis was guided by Braun and Clarke (2006), the first stage of which was to re-read the transcripts and begin to code relevant sections according to common themes (Braun & Clarke, 2006). Some of these initial themes had been identified during the narrative analytic process; however, others were guided by the research question and theoretical knowledge. By coding a number of transcripts this way, some consistent themes were identified within and across transcripts of participants’ narratives.

During this process I was primarily interested in the semantic themes, i.e. concerned with explicit meanings of the data (Braun & Clarke 2013). However, in line with a critical realist epistemology, these semantic themes were acknowledged as representing each young person’s own perspective located in a shared cultural context. These initial themes were developed through an iterative process of going back and forth between the data and coded extracts to identify and refine common themes and sub-themes. These were reviewed and reworked a number of times, sometimes resulting in multiple themes being combined into one, or alternatively being discarded altogether. The remaining themes were then named and defined, before being written up into a coherent argument, with a focus on using vivid and compelling excerpts to illustrate each theme using the participants’ own words.

Ethical Considerations.

A number of potential ethical issues were identified in this research, including the need to ensure participant anonymity, informed consent and to manage the potential for psychological distress due to the subject matter of narrative interviews. Prior to engaging in
the research, participants were provided with detailed information regarding the nature and purpose of the study and were required to sign a consent form stating that they understood and agreed with how their information would be used. They were also informed that they would be able to discontinue participation at any point of the interview, even if it had already begun. Participants were informed that following completion of the face-to-face interview, they had up to two weeks to request that their information be excluded from the research. Participants were advised that the information discussed during the interview would be kept between myself, the research supervisor and the university approved transcriber. The information they shared would only be used for the purpose of this doctoral thesis and associated research publications, with anonymity protected by using pseudonyms and altering narrative details that may identify a participant.

At the start of each interview, participants were reminded that if I became concerned about their safety during the interview, I would be obliged to take necessary steps (including possibly breaking confidentiality) to support them to stay safe, as required by The New Zealand Psychologists Board Code of Ethics (2002). Any decisions about breaking confidentiality due to matters of risk would be made in conjunction with the researcher supervisor who was an experienced clinical psychologist.

During interviews, participants were required to actively reflect on and talk about their experiences of mental health issues, a process with the potential to elicit upsetting memories and cause emotional distress. As the young people involved in the research were employed on the basis of their personal experiences it was deemed unlikely to be the first time they had spoken about their experience. Nonetheless, the risk of becoming distressed during after the interview was explicitly discussed with participants at the outset of the interview. As I was undergoing clinical psychology training during the time of the interviews I possessed some knowledge and skills to help support participants if they became distressed.
The research supervisor, an experienced clinical psychologist, was available to be contacted during or after the interview if needed.

There were a number of participants who became tearful during the interview. In the case of two of these interviews, I offered to pause the interview however both of these young people elected to continue and finish the interview. Young people were offered information regarding counselling services and psychological support at the completion of the interview, but they all suggested they had existing personal and professional support networks they could (and/or would prefer to) call on if they needed support after the interview. The follow up phone call offered a way for to check in with people about how the interview process had affected them, and to offer support if required.

**Trustworthiness and transferability.**

Trustworthiness is described by Sandelwoski (1993) as the foregrounding of the practices or decision-making process of the researcher, to make it “auditable” by the reader. In other words, it is the researcher’s job to provide a transparent account of the research in order to help the reader decipher its trustworthiness, and ultimately its quality (Sandelwoski, 1993). The process of the present study is well documented, including research design, methods, analysis and conclusions, so that it is visible and open to scrutiny. Detailed documentation of research processes and researcher position is also related to transferability, another measure of qualitative research quality that has been suggested (Shenton, 2004). Transferability refers to the research having implications that are useful or applicable to wider settings, which is of key importance to the present research. Shenton (2004) also argues that clear documentation of research is important as it allows other researchers to do the same work, without the assumption that they will or should produce the same results. Reflexivity, which I have discussed earlier, is also seen as important in maintaining the rigour of qualitative research. I have reflected on my own role in this research throughout the
process and engaged in critical discussion with my supervisor in order to facilitate this further.

Summary

This chapter has outlined the critical realistic epistemology and narrative approach which underpin this research, as well as the specific methods of data collection and analysis that were utilised. After eliciting narrative accounts from the 12 young people who agreed to participate in the research, narrative and thematic analysis was conducted to explore the research questions. The following two chapters present the findings of these two analyses.
Chapter Four: Narrative Analysis
Recovery, a Personal Journey

This chapter will present an in-depth analysis of the 12 narratives gathered during the interview process. The purpose of the narrative analysis was to gain insight into how participants made sense of their experiences of mental health difficulties and recovery. During the analytic process, it was identified that the way young people made sense of “the problem” and their self in relation to the problem, shaped how they constructed their experience of “getting better.” The narrative patterns identified have been captured in five narrative types entitled: “sensitive self”, “bad choices”, “not me, the situation” “surviving the chaos” and “product of the system”. Although for the purpose of analysis, narratives have been extracted and presented as coherent and unique types, they are not entirely representative of any one young person’s story, which often contained vestiges of other narratives. However, participants’ stories were included under each narrative type insofar as they provided a good example of the key narrative themes. Each narrative type attempts to capture the key essence of stories that are similar in terms of their positioning of “the problem”, “the self” and “recovery” and other related themes that were identified. For each narrative type, a very brief introduction is followed by an exemplar story–one young person’s story that illustrates the key characteristics of the narrative–which is followed by in-depth analysis of the exemplar story and others that fit with the narrative type.

The “Sensitive Self” Narrative

In the “sensitive self” narratives, mental health difficulties were fundamentally constructed as the result of innate sensitivity. Although in some cases stressful life circumstances were suggested to have played a contributing role, these were framed as triggers rather than causes. Recovery was described as an ongoing process of self-discovery and learning how to manage
this innate sensitivity. Overall, the “sensitive self” narrative type was progressive and characterised by a tone of acceptance, with mental health difficulties constructed as providing an opportunity for personal growth and innate sensitivity as a virtue. The three young people whose stories best illustrated this narrative type were Jayita, Charlotte and Chris.

**Jayita’s story**

Jayita, a Fijian Indian woman in her mid-twenties, positioned anxiety as having been part of her life for a long time, and began her story by saying she had “always been anxious”. She described herself as very awkward growing up and recalled feeling like she didn’t fit, partly because she was “half-caste”. She struggled at school and found out belatedly that she was dyslexic. On reflection, she felt the combination of being dyslexic as well as an “anxious person” had really impacted her. Jayita’s anxiety intensified during her high school years. During this time she became increasingly self-conscious, experienced “more ups and downs” and eventually became depressed. She described this as a gradual process:

I don’t think there was a starting point but I think a lot of it was about image and self-esteem….and then I think what triggered major depression and all that stuff was, during my teenager years my dad’s mum passed away–and then my Dad got diagnosed with cancer. Um terminal...

When Jayita experienced her first “major down” during the last year of high school, her feelings of not fitting in intensified, she withdrew from everything and spent a lot of time alone. She described this year as being extremely difficult, and reflected “honestly, if I was 18 now, I wouldn’t have believed that I was alive. Like I didn’t think I would make it past 21”.
Although Jayita hoped things would improve when she left school, when she was 19 years old, her father died of cancer. She described how this led to “two really big episodes where I was like ‘Holy shit. I just want to die’”. Jayita described the fact that she didn’t act on suicidal thoughts as being a coincidence, saying “every time I got to the point I was that depressed, either mum intervened or I chickened out”. When Jayita felt really down she would find ways to elicit help without explicitly asking for it. On one occasion Jayita showed her mother a picture from social media as a way to communicate her own wish to harm herself. Her mother called a mental health crisis team and Jayita was accepted into mental health services. She was prescribed anti-depressants and after trying a couple of different types, managed to find one that was “really good” for her.

After finishing university Jayita spent time traveling overseas, which she enjoyed, but soon after arriving back in New Zealand she experienced another “down”:

That was another down for me ‘cause I was like ‘oh crap!’ The whole responsibility thing that I was trying to avoid and the whole ‘I am going away to get better myself’ and then realised coming back that actually nothing really improved other than having this awesome experience but I didn’t really work on myself.

Taking responsibility for “working” on oneself was a key aspect of this narrative type and positioned as crucial to recovery. Overall, Jayita described recovery as a long, ongoing process of ups and downs, punctuated by moments of clarity about the process of getting better. These realisations were not necessarily followed by things immediately improving, but rather represented part of an iterative process of self-development and self-improvement which enabled her to better manage her inherent sensitivity. She had another one of these moments during her Wellness Recovery Action Plan (WRAP) training, describing how the course helped her to realise that despite her sensitivity, she did have some control over how
she managed her mental health. After completing additional peer training she was offered two jobs, one of which she accepted. Jayita described working in mental health as having a positive impact and making her stronger. Jayita also positioned her work as aiding recovery through encouraging self-awareness and creating further impetus for her to work on herself, saying “I think being in that field gives you an awareness of yourself and I think, you kind of have to really work on yourself”.

Jayita described getting better at managing her sensitivity over time, because the alternative—not managing—was so awful:

Yeah so I guess I have gotten better with it as I have gotten older, maybe because I am sick and tired of this shit. I really don’t like being depressed. I hate it and I think it is the worst thing possible ‘cause it consumes you physically and mentally.

She also described feeling (somewhat begrudgingly) that she has to accept that anxiety and depression may continue to be a problem for her:

I don’t want to say that I am always going to be anxious and depressed because I hope that I won’t be, but I mean I have to acknowledge the fact that I do have a predisposition towards it. Like my family has it, both dad and mum are anxious people, there is addiction problems in my family, there is schizophrenia in my family. So I do kind of have a predisposition to being overwhelmed by things...in terms of making sense of the whole thing, it’s just me

In line with her conception of having a predisposition to feel overwhelmed, recovery was not described as the permanent cessation of symptoms, but rather as improved capacity to manage. Staying well was positioned as requiring continual engagement with the project of self-improvement to maintain resiliency. Jayita positioned herself as relatively successful in this project, saying: “Fuck, you know, I am actually really proud of myself”. She described
an increased sense of agency and explained that, while she used to need other people to help her, she had become better at both recognising when she needed to seek help and taking the responsibility to do so. Jayita joked that she was a hypochondriac, describing visiting her GP frequently, not necessarily for mental health issues but to try and fix various things about herself, saying “I just like to work on myself and that is kind of how I lift myself up”, suggesting that the process of actively working on herself offered relief. Jayita described that by pre-emptively planning to manage her sensitivity she could decrease the likelihood that her vulnerabilities would be triggered into full-blown distress. When interviewed, she was planning to start further university study and was quite anxious about how she would cope with the academic stress. However, she had already made plans to “get into all the services I can… just in order to keep myself well and prepared for everything… I am slowly developing a plan”.

Jayita’s narrative epitomises the “sensitive self” narrative type. Throughout her story she positioned herself as being “an anxious person” and that as such, having periods of acute distress was inevitable. At times it seemed as though she downplayed the level of grief and loss she had actually faced, particularly in relation to losing her father and grandmother. Charlotte spoke about herself in a very similar way, describing herself as “an anxious child” and saying “I think I was always just probably going to head that way at some point or another”. Likewise, Chris also explicitly constructed his distress as innate and as having a strong biological component, frequently referring to his grandfather who had also been diagnosed with bi-polar disorder. The below quote illustrates the impact this genetic understanding had on Chris and his family:

My mum was like—cause of the genetic thing in the family—she just felt the weight of that, that I had it. Like she hasn’t felt like that for ages now because we have all
adjusted to me living with it but she did feel like it was her fault. Which was tough for me too because obviously it’s not, so it’s sad.

While Jayita described the influence of culture, her “heavy” build and dyslexia as contributing to her feeling out of place, these influences were constructed as amplifying the effect of her “predisposition to feel overwhelmed” rather that causing it. Both Jayita and Charlotte described how external stressors tipped them over the edge and contributed to them becoming acutely unwell. Charlotte said things started to go downhill when she had a “really stressful year” at age 13, citing the start of high school, onset of puberty and her parents separating as contributing factors. However, she later appeared to downplay the level of stress saying “obviously for me it didn’t take a hell of a lot of stress”.

Like Jayita, both Chris and Charlotte described experiencing periods of “ups and downs” over a number of years. It was during these periods of “downs” that young people described having contact with services or other helping professions. Both Jayita and Chris described their parents as initially playing an important role in facilitating their help-seeking. Charlotte also didn’t initially seek out help herself–after having a panic attack at school she was sent to the guidance counsellor who then referred her to mental health services. Overall, experiences with helping professionals and the mental health system were described as being mixed, with positive experiences largely related to clinicians and medication being a “good fit”. However, in these stories, much more emphasis was placed on internal factors–such as deciding to actively engage and take responsibility to work on the self–rather than relying on professional advice or assistance.

Over time, all three of these young people described experiencing a shift from needing others to help them towards actively managing their own mental health. As such, recovery was constructed as an on-going process of learning how to manage sensitivity to
reduce the likelihood of being triggered into a period of acute or more serious distress. Jayita and Charlotte recalled having internal moments of clarity when they realised that they needed to and could “get on top of things” despite their innate vulnerability. These moments of insight and increased self-knowledge punctuated the recovery process and ultimately led towards more active engagement with the tasks of managing better and taking responsibility for their mental health. Similarly, Chris described that since his last period of being acutely unwell he had “changed a lot I think, taken more responsibility for myself”. Chris described experiencing “danger moments” when he worried about becoming elevated—such as feeling a natural high after playing a gig with his band—however said he now had “the tools” to take a step back, check in with himself and ask “what’s happening for me?”.

The ongoing process of self-management that these young people described appeared linked to an expectation that they would likely become unwell again in the future. In this sense, recovery was not described as the permanent absence of symptoms, but rather new found self-awareness and the ability to respond more quickly. This aligns strongly with the definition of personal recovery that emphasises holistic personal wellbeing over a complete symptomatic cure (Slade, 2009; Anthony, 1993; Davidson et al., 2005; Tew et al., 2012). Jayita explained that she had developed new skills and now had the ability to “put a plan in place” when she wasn’t coping well. Chris described that learning to communicate better had been an important part of his journey, illustrating the strong connection between recovery and self-improvement in these narratives. Like Jayita, Chris also described his work in mental health as supporting recovery’s key tasks of self-disclosure and self-improvement. He explained “it’s all about self-awareness and practising doing that in a relationship with someone else in recovery, it really helps you do it with yourself as well”.
Although each participant spoke about unhelpful experiences that contributed to their difficulties or hindered recovery, the overall tone of these stories was one of acceptance. Chris described:

I think being diagnosed with something you feel different, but different is never [pause] a curse sort of thing you know. I am using it now to get a job and support others who are distressed and change stuff like that. And I really wouldn’t be anyone else…

Charlotte expressed a similar sentiment when she said: “I will go through depression again at some point no doubt and that sucks and it’s also okay”. Like Jayita, Charlotte didn’t sugar coat her experiences; however, she did highlight how experiencing psychological distress led to personal growth:

It was awful. It was really, really horrible. But you learn so much from it and I think I am more of a [pause] whole person now and you know, I know myself quite well and it puts me in a better position to sort of work with others and see what others ... I don’t know. It’s made me who I am and actually I’m okay with who I am now so it’s sort of all good.

These quotes from Chris and Charlotte illustrate an important characteristic of the stories: that experiences of distress have been accepted and integrated into the present day sense of self. All three young people constructed increased strength and personal growth as emerging out of their experiences. In this sense, this narrative type can be understood as having an overall redemptive quality (McAdams, 2006; McAdams & McLean 2013), in that the negative experiences associated with significant psychological distress have been transformed into an emotionally positive outcome. Chris related this directly to his ability to do his job, saying “I don’t know who could go through what I’ve been through, my experience, and not be empathic… Someone can learn to be as compassionate and as
empathetic as someone with the lived experience but it’s just difficult”. He praised his current work place for providing the “the opportunity to turn that adversity into an advantage and get a job because you have been ill”. These sentiments reflect wider cultural ideas about there being “silver linings” to adverse experiences, often in the form of increased strength or resilience, as well as the underlying philosophy of peer support (Dennis, 2003).

Innate sensitivity itself was also positioned as having intrinsic benefits. Charlotte described how her sensitivity meant she had a rich emotional life: “I feel that range of emotions and that is a lot of who I am and I quite like that”. Similarly, Chris positioned his sensitivity as intrinsically linked to his creativity:

Being sensitive I guess and creative, I think those two things come together, because it’s hard to create anything or even care to create anything when you are sort of more bullish, and like not that observant or sensitive to pain or joy or whatever in-between.

As well as representing one element of the redemptive arc of these stories, positioning sensitivity as a virtue also reflects the cultural counter narrative of “the highly sensitive person” (Aron, 1997) which promotes benefits of being “highly sensitive” as being more empathic, perceptive and creative (Wachter, 2014). This idea developed out an influential book published by Elaine Aron (1997) and subsequent work that suggests that different levels of sensory-processing sensitivity, or different levels of the “highly sensitive” trait, account for people being more or less impacted by environmental stress (Lionetti et al., 2018). On the one hand, positioning sensitivity as an intrinsic virtue can be seen as beneficial and as facilitating the acceptance and integration of the “sensitive self” into present-day identity. Narrative research that examines how people adapt after significant, negative life events, suggests that being able to make meaning out of one’s experiences, construct a positive outcome, and integrate the experience into the present day identity, is associated with higher
levels of subjective wellbeing and psychological health (McAdams et al., 2001; McAdams & McLean, 2013). However, it also appeared to go hand-in-hand with a strong sense of personal responsibility to keep well. Chris exemplified this when he commented:

I stopped taking my meds... maybe once. I learnt my lesson. But even then it felt like you let everyone else down and... I got unwell so I felt like I was letting me down because I wasn’t the best me.

The sense that he “let people down”—including himself—illustartes how this sense of responsibility to manage and be ones best self at all times, may feel burdensome. Importantly, Chris did not portray his responsibility to take his psychiatric medication as a neutral activity. While aspects of his narrative reflected the biomedical model, when speaking about psychiatric medication he reflected:

They always say ‘it’s not different from taking heart medication’ but for something that is changing like, who you are and how you behave, it is a bit different. Because, someone is saying like ‘the way you were born won’t fit’. You know, ‘the things that you will experience as a person without the stuff that we have created in a lab, it makes people uncomfortable to be like who you are chemically or brainily’.

The way Chris talks about this suggests that being diagnosed with Bi-Polar Disorder and having to take medication for it has significant implications for his identity. He also explained how he had started to think about the fact that mental health issues are less prevalent in the third world:

I feel like they just get on with living because they have to, because life is so—it’s like a survival. So maybe... it’s more a society thing... I hate to say it but it’s sort of how I’m
thinking, we can afford to—sounds terrible hey? I mean us being relatively idle and comfortable might contribute to it as well.

Chris’s suggestion that mental health difficulties could be linked to contextual factors may be hard to reconcile with his current emphasis on genetic predisposition and personal responsibility. Many researchers and theorists have highlighted that one of the pitfalls of living in a late-modern society like New Zealand, is that any form of perceived failure or problem is seen as the result of individual faults (Bauman, 2007; Beck & Beck-Gernsheim, 2002; Schwartz, 2004; White & Wyn, 2013). So while in many ways, the acceptance and strengths–focused tone of this narrative type could be considered “positive” and helpful to these young people, believing that something is caused by an innate personal attribute also potentially burdens these young people with a heavy responsibility to carry forward in their lives.

The “Bad Choices” Narrative

The “bad choices” narrative type describes stories in which mental health difficulties were positioned as a direct result of using drugs and alcohol. After hitting rock bottom (multiple times) young people described having to learn to take responsibility for their well-being. In contrast to the protagonists in the “sensitive-self” narratives, who described taking responsibility for their inherent sensitivity, these young people emphasised being responsible for making wise choices that were largely described as taking medication, avoiding substances and living a healthy lifestyle. While changing their lifestyle and taking responsibility for good choices was positioned as crucial, genuine recovery was also described as requiring acceptance and support from others to really “heal”. Recovery ultimately led to a return to their pre-substance use, pre-unwell self, albeit a wiser, stronger,
more responsible version. Distress was positioned as being in the past, provided the responsibility to stay well was upheld. Kalena, Isieli and Vijay’s stories included many elements of this narrative type.

**Kalena’s story**

Kalena was about 13 years old when she started experimenting with drugs and alcohol and said “I loved it from the moment I touched it”. As well as being fun, drugs and alcohol made her feel okay and counter acted feelings of being different that had crept in after a traumatic experience at age ten. Kalena described that when she was younger, she had been a high achiever at school and had done well at sport. However soon after she started “drugging and drinking” she lost interest in school and stopped doing everything she had previously enjoyed. Her mum had been in recovery from substance addiction for over twenty years and “wouldn’t put up with that nonsense”, so Kalena had to leave home at 15 and left school shortly after. Later that year, she had a brief experience of psychosis after taking “something” at a party. Kalena came right after about three days but commented “that should have probably been enough to tell me that I probably shouldn’t go near that stuff, but I had to learn that lesson a few times over”. This comment illustrates one of the key themes in this narrative type–substance use was a personal choice (albeit a naïve one) and that the “lesson” of its potential risks had to be learned the hard way.

Kalena continued to party a lot and at 17 started experimenting with meth. Not long after this she had what she referred to as her “first episode of drug induced psychosis”–clearly positioning her distress as a direct result of her substance use. She remembered behaving in strange ways and believing bizarre things, and thinks her mother took her to the emergency department. She was admitted to hospital and spent two months in an adult inpatient unit, which (at the time) she felt extremely embarrassed and ashamed about. In hindsight she believes a lot of this shame was related to the stigmatising ideas she had held
about mental health issues and “psych wards” before she became unwell herself, explaining that prior to her own experiences she didn’t have “a whole lot of empathy for people in that situation, I didn’t understand”. Kalena described a profound sense of loss during this time, feeling as though she had not only lost her “sense of self” but also her social supports, as her previously large group of friends dwindled.

Kalena experienced her contact with (adult) mental health services as frightening and once discharged from hospital, felt as though she was largely “left to her own device”. She was prescribed what she now considers a high dose of anti-psychotic medication, which numbed her and made her feel like a “zombie”. She described continuing to take the medication because she thought she had to, not realising she could ask to change it. Kalena constructed this inadequate and inappropriate care as amplifying the impact of her distress, and potentially making it harder to get better. However, during a burst of energy one night she “got a glimpse” of her old self. She described how that experience gave her a lot of hope: “It was like ‘oh my gosh, it is still in there, I still have that. I have just experienced it so I know that I can get it back’”.

This glimpse of hope and reconnection with her old self appeared to motivate Kalena to take responsibility for her life and make some changes. She “cleaned up”, stopped using drugs and alcohol and said things were going well until a “domineering” new partner pressured her to stop taking her medication. Kalena was very reluctant as she knew she would get unwell; however, she described herself as too vulnerable to resist his pressure. This led to another two months in hospital, after which she didn’t bounce back so quickly. While in hospital the doctors warned her that if she kept getting unwell, there would be less chance of a full recovery. She described this as a turning point for her “I really took that on board and I was off work for a good year and a half…I actually got well”. The idea that one needs to commit to taking responsibility for their own wellness is a key aspect of this
narrative type. For Kalena, this meant not only staying away from drugs and alcohol but also becoming stronger in herself so she was not so easily influenced by those around her.

In addition to personal responsibility, feeling accepted and supported was described as an important part of genuine recovery. During a period when she was “still not one hundred percent well”, Kalena spent time at a peer support facility and was encouraged to attend peer employment training. She described how this course helped her to heal, saying:

That was probably one of the best decisions I have ever made...Going into that place I felt 100% accepted and just really, really comfortable. Their care was genuine and I suppose that was the start of my healing.

At the time of the interview, Kalena had worked in peer support for over five years. She described this work as not only helping her grow professionally but also helping her to rebuild her self-esteem. Kalena said she hadn’t had a relapse for five years and described a real sense of responsibility to stay well “I just can’t run the risk of getting unwell, I just absolutely can’t, it is my biggest fear”. Kalena described the right medication as a key part of her recovery saying “it’s the first thing on the list”. Being in a healthy relationship where she feels accepted for who she is, and taking care of herself in other ways—maintaining balance, reducing stress—were also deemed important. She commented “sometimes it can be a little bit selfish but I am not going to be any use to anybody if I go back to that place that I was at those other times”. This quote illustrates the progressive nature of the “bad choices” narrative type—life was positioned as improving, and recovery as a process of personal growth leading to a return to a wiser, more responsible version of the person they were before their experiences of being acutely unwell.

Kalena’s account provided a good example of the “bad choices” narrative type. She positioned substance use in early adolescence as a personal choice that ultimately resulted in
her becoming unwell. Despite mentioning that both of her parents had experienced problems with addiction, Kalena never explicitly connected this to her issues and focused instead on her own responsibility for her substance use. She did describe that using substances helped her cope with the impact of a “traumatic” experience at age 10, but mentioned this as though providing contextual information rather than explaining factors that contributed to the development of “the problem”. While trauma and parental substance abuse are described in psychological literature as being risk factors for the development of both substance abuse and psychological distress (e.g., Anda et al., 2005; Johnson & Leff, 1999), Kalena’s narrative did not strongly reflect these ideas. Rather, she described her drug and alcohol use as resulting from naïve choices, reflecting common cultural narratives about young people taking risks and making mistakes from which they need to learn from and may have to pay a price for (Kelly, 2000; Kelly, 2007). As a young adult, Kalena appeared to take full individual responsibility for not learning her lesson about substance use more quickly.

Similarly, Isieli described his personal choice to use drugs and alcohol as linked to his desire to be cool and “part of a crowd”. He did not provide much contextual information about his background apart from citing his ethnic background and that his family were very religious. Like Kalena, Isieli’s family did not approve of his bad behaviour—he was labelled “the black sheep” and kicked out of home. This led him to living with the friends he used drugs with, and escalating substance use. Isieli described getting into a lot of trouble during this time and while he didn’t feel proud of this behaviour, he seemed to rationalise it by saying “I guess that was just my way of experiencing life and discovering things”, also reflecting the idea that young people learn from their mistakes. Like Kalena, Isieli also described being accepting of his diagnosis of drug induced psychosis, saying “that gave me a fair idea why I was hearing voices—probably because of the amount of drugs I had been doing”.

In this narrative type, young people described their drug and alcohol use as initially meeting a need to fit in, feel connected and have fun. However they described having to “pay the price” for their bad choices, describing significant loss of connection, agency and sense of self and associated feelings of shame, isolation and hopelessness. Kalena described how being hospitalised felt embarrassing and shameful, and signified that she was “different” to her friends. Kalena attributed much of her self-stigma to pre-existing ideas about mental health issues, which fits well with both adult and youth models of self-stigma, which pre-existing endorsement of prejudice against mental illness is proposed to play an important role (Corrigan & Watson, 2002; Kranke et al., 2011). At this point her sense of personal agency was constructed as almost non-existent and she described herself as vulnerable and alone.

Vijay also lacked agency during his time in hospital, describing that he was treated like a child and his medication was increased every time he tried to speak to a doctor. Vijay also lacked support and connection during this time and described feeling like the nurses were his only friends. For Kalena, being put on too much medication was significant in that it made her feel like she was “not herself” and she described a sense of losing herself during this time. Likewise Isieli commented that “the things that I used to love doing, I lost interest in”. He also felt ostracised, stigmatised and ashamed, largely due to his family’s response to his substance use and “mental illness”. He explained:

Every time I do anything wrong at home they would call me names because of my drugs and call me crazy because of my mental health and that sort of led me to depression… hearing those kinds of comments from my own family, it lead me to a sort of spiral….

In the “bad choice” narrative, the road to recovery was constructed as having two key elements: taking responsibility and making “good” choices to redeem the bad choices made
previously, and; feeling genuinely accepted and supported by others, which helped young people overcome the stigma they had experienced. Kalena described how she “found AA and NA and cleaned up”. Getting clean and staying away from drugs was described as a key “good choice” for all three young people. Vijay described how he learnt to stay clean by avoiding certain situations and learning to say no. As the “bad choices” narrative progressed, young people described their agency increasing as they took on more self-responsibility. Kalena moved from positioning herself as a passive, vulnerable recipient of “too much” medication to actively engaging with the process of making it work for her: “it was a bit of a long road to find the right one… I have had to be quite creative… it can be quite a balancing act”. For her, another aspect of taking responsibility and increased agency was developing the strength to stand up to partners who thought she shouldn’t be on medication. Kalena said now she “would never run the risk of not taking them because I have tried a few times and it just ends up really badly”.

This internal process of developing agency marked the turning point towards recovery in the “bad choices” narratives, and was positioned as more important than specific professional or personal help that was received. However, feeling genuinely accepted or connected to both helping professionals and family was described as facilitating the possibility of change in this narrative type. For Isieli, taking responsibility largely involved deciding to genuinely engage with services. He described his initial engagement with services as superficial; however, one positive relationship with his key worker, along with stern words from his doctors, helped him to “take it seriously” and engage more genuinely. Isieli described another key point of his journey as being when a serious suicide attempt changed his parents understanding of what he was going through, which led them to become much more supportive and understanding.
Identity was described as relevant to recovery in this narrative type. More specifically, young people described a return to the version of themselves that had been lost while using substances, being acutely unwell or over-medicated. However, emphasis was put on the fact that they were a wiser, more responsible version of themselves. While Kalena explicitly spoke about a process of reconnecting with her old self, Isieli described this theme in the more practical terms of “getting his life back”. He described getting involved with activities he had enjoyed “before” he was unwell, such as working out at the gym and playing rugby. Through these activities, Isieli reconnected with some of his old friends, but spending time with them in more positive, healthy ways. He contrasted this to the “old lifestyle ways of going to someone’s garage to drink or smoke”. Vijay expressed a similar sentiment about his bad choices being behind him when describing how after a drug use relapse he immediately regretted it and felt “this isn’t my life anymore”.

During the interview, Vijay described how song lyrics from the rapper Jay Z related to his life, saying “When I was young I was foolish but now that I’m wise, I might as well be wise beyond my peers”. This encapsulates the key message that young people can learn from their mistakes and become wiser as a result. Both Kalena and Isieli communicated a sense of pride about how far they had come, with Isieli commenting “I am really proud of myself, I couldn’t say that before”. Through taking responsibility and getting life back on track, these young people positioned themselves as undergoing a personal redemption process (McAdams, 2006; McAdams & McLean 2013). They also described feeling as though they had grown as people and were now wiser, more compassionate versions of themselves which was associated with feelings of pride. In a sense, the “bad choices” narrative can be seen as optimistic and empowering. All of the young people in this narrative type had been given diagnoses of psychotic disorders at some point, yet their stories resist dominant ideas about psychosis being untreatable and instead, emphasise personal growth, development of agency,
and gratitude for a second chance. Being acutely unwell was positioned as being behind them, providing they continued to maintain wellness through responsible, positive choices.

However once again, this emphasis on personal responsibility leaves little space for the acknowledgement of more contextual factors, including the impact of trauma (Anda et al., 2005) and higher rates of “schizophrenia” diagnoses in populations of ethnic minorities (Kake et al., 2008; Sachdev, 1997). Considering all three young people in this narrative type self-identified with ethnic groups considered minorities in New Zealand, narratives that highlight contextual factors could be considered relevant. It has been suggested that locating the cause of mental health difficulties as a result of personal choice, may act to undermine the well documented influence of sociocultural issues on psychological distress and ultimately reduce the impetus to try and address these issues (Read, 2004). Also, considering the profound impact on physical health that long term use of anti-psychotics can pose the strong sense of responsibility to continue taking these medications also has implications for these young people (Hennekens, Hennekens, Hollar & Casey, 2005; Newcomer, 2005; Young, Taylor & Lawrie 2015).

The “Not Me, the Situation” Narrative

In this narrative type, young people constructed their mental health difficulties as developing in response to extremely challenging situations. This was often linked to significant issues with their family (including abuse) as well as social and academic pressure at school. Despite locating the cause of the distress outside of themselves, young people still described themselves as not coping, identified with diagnoses and cited professional intervention as being helpful. Getting better was constructed as a gradual process that was heavily influenced by growing up and related changes in circumstances and increased
autonomy. The three young people whose stories included this narrative type were Sam, Jared and Aasha.

**Sam’s story**

Sam, who identified as non-binary, started off by saying “I’ve had a very surface brush with the whole mental health system thing because a lot of my issues were situational”. While Sam remembered being “a very shy kid…a very easily scared kid” this wasn’t positioned as representing an innate sensitivity, but rather as a response to the frightening environment they grew up in. Sam described their mother Jenny as abusive parent who also had mental health issues. When reflecting on growing up, Sam remembered experiencing “a lot of low level gas lighting, like you know, you have a view on something that happened and it’s like ‘no–it happened this way’”.

Around the time Sam started high school, the situation at home deteriorated. Sam explained “when it comes to abusive parenting and stuff it does tend to kick off when people are younger teenagers, because that’s when they start to actually be a person”. Sam also experienced intensifying pressure at school and referred to Year 10 as “the year when everyone flips their lid”. At the same time, Sam went through a relationship break up and ended up “between social cliques”. Sam described not knowing how to cope with all of these pressures, leading to feelings of “depression”; however, seemed to see this response as understandable.

Sick of feeling depressed, Sam went to the GP who said they would refer Sam to a counsellor, but this never eventuated. Sam described pulling through and being “okay”, but found the experience frustrating. Things continued to get worse and the following year, Sam increasingly realised that “things in my family were kind of messed up, and that was starting to impact me mental health wise”. The conflict at home escalated and was often blamed on Sam “being too sensitive”. Sam didn’t appear to identify with this label of sensitivity, but
rather saw it as an attempt by their mother to undermine normal emotional responses. Sam sought help again, this time from the school guidance counsellor. The counsellor referred Sam, and their parents, for family therapy. Sam’s recollection of this was: “that did not go well, by which I mean my parents think it went great and I spent every session but one curled up in the corner of the couch crying, um so, he was bad.” The family therapist did however refer Sam to youth mental health services, through which Sam was able to access to individual counselling for almost two years, which was much more helpful.

For much of Year 11 and Year 12, Sam felt hopeless and remembered thinking “is this ever going to get any better? I don’t think so”. They remembered having frequent experiences of “dissociation” and not feeling connected to anything. During this time, the pressure of academic assessment was increasing and Sam described how the school “wound up everyone about their exams to make people afraid to fail…like we burnt out quite hard”. Sam was struggling with sleep that year and attributed this in part to having a teenage body clock that didn’t fit with school hours. During that final year of high school, Sam remembered feeling like “I’m just not going to make it”. Even though friends and classmates were concerned, they didn’t really know how to help. Sam said: “I guess I didn’t really know what I needed either ‘cause it was nothing that anyone could fix”. There was a strong sense in Sam’s story that an age-related lack of agency meant it felt impossible to change anything about the stressors and pressures they were facing.

While never officially given a diagnosis, Sam started taking medication as a “stop gap” measure. The medication was for anxiety and Sam remembered being told “this is to help you with your situation”. Sam explained that “situations do things to you and sometimes those things look like the specific mental illnesses”. Counselling also helped Sam survive the last difficult year of school. Sam described finding this helpful and said it was really nice
“just to have someone like who believed me...nice to basically have someone validate me”.

Sam described feeling like their counsellor really understood the situation:

I think he recognised very early on that we weren’t trying to treat a problem with me, we were trying to deal with a situation and so it was very tailored to that, um which was quite helpful.

Towards the end of the year Sam started to “come out the other side”. Exams were finished and a room became available in a flat with friends. Sam felt extremely supported by these friends who encouraged Sam to “get out” of the family house. Soon after moving into the flat, Sam started at university and things got a lot better. The transition out of home and school were positioned as playing a fundamental role in things improving. Sam described still finding things difficult at times, saying:

There was definitely a couple of points this year where I skated right by depression. But you know, it’s kind of just identifying things that knock me, like that stop my momentum and stuff and trying to avoid them.

Once again, the emphasis appears to be on aspects of the external situation that might knock Sam, rather than any innate personal attributes. Sam described exercise, a routine, healthy eating and general self-care as being helpful, as well as very limited contact with their mother. At the time of the interview Sam was no longer taking medication and reported feeling fine, however attributed this largely to being “under zero pressure now that exams are done”, directly positioning distress as a consequence of external stressors.

Sam’s story clearly illustrates the key theme of this narrative type–that mental distress was a response to circumstances rather than being driven by internal personal attributes or choices. Similarly, Aasha began her story by saying “I guess for me and my mental health issues, it wasn’t really about me”. Aasha also had a particularly bad relationship with one
parent, whom she described as violent and abusive. All three young people mentioned that either one or both of their parents had mental health difficulties. This information wasn’t explicitly used to provide evidence of a predisposition towards experiencing distress, but rather as one of the environmental stressors the young person was facing.

Jared described difficult step-family dynamics at home as contributing to his low mood, but explained that, primarily he had “had a hard time because I moved around a lot”. After his parents divorced he lived in a number of different cities which made it difficult for him to maintain friendships and caused him stress related to trying to fit in at new schools. These young people’s views on the cause of their psychological distress is consistent with research that suggests the general public most frequently attributes psychosocial stress as the cause of “pathological behaviour” (Angermeyer & Dietrich, 2006; Read & Harre, 2001).

Although distress was positioned as a response to external factors, all three young people described “feeling depressed” and also referred to other diagnostic labels. Like Sam, Aasha described becoming depressed as a gradual response to the cumulative impact of stressful events. She remembered noticing that “the bad days” were getting longer and more frequent until it “got to a point where I couldn’t really remember the last good day.” Aasha positioned the lack of agency she felt at the time as leading to the development of her eating disorder: “Because I felt really unhappy with my life at school, I didn’t really have a safe space, I turned to kind of changing things by changing my body”. Aasha’s body appeared to provide her with a way to exert agency when she felt no control over other aspects of her life.

In the “not me” narrative type, help seeking and service use was positioned as profoundly impacted by the limitations of age—and the associated lack of independence and agency. Sam actively sought help from both the school counsellor and the GP, but without supportive parents, described it as a “struggle” to engage with the health system. Likewise,
Aasha described spending “almost half the day” to get to and from appointments and having to catch multiple busses across town because her parents were not supportive of her engaging with mental health services. Overall, experiences with health professionals were described as mixed. Aasha remembered feeling “so overwhelmed by everything” that she couldn’t really engage with the therapy being offered to her when she was first using services. She also described the therapist’s approach as being unhelpful because it didn’t fit with her own understanding of what was going on:

She’d talk about changing my thoughts and I found that really insulting…You know, like ‘This is you. There’s something wrong with you and the way you think and you just need to change that and then you’ll be better’ which long term, looking back it wasn’t. It was more of an environmental change.

Aasha described a completely different experience with a subsequent counsellor who supported her in practical ways to gain her independence and also disclosed that he had grown up with an abusive parent too. His disclosure and practical support appeared to communicate to Aasha that he really understood what she was going through, and was therefore able to help with an appropriate solution. This mirrored Sam’s sentiment when describing how their counsellor had recognised they were trying to “deal with a situation”.

These quotes illustrate how mental health professionals (and friends), who were perceived as viewing “the problem” as situational, were positioned as allies.

For Jared, therapy provided new insight into what was going on for him and helped him take less responsibility for some of the sad family events he had experienced. He described how the therapist said “you had these things happening around you,” which Jared found “weird” but also “really helpful”. Sam and Aasha also constructed medication as playing a role in things improving for them. Sam positioned anxiety medication as a short-term solution
that helped to survive the situation, while Aasha described medication as being an important part of her long-term recovery. Jared on the other hand strongly resisted medication throughout his contact with mental health services.

Although medication and support from friends and professionals was described as helpful, overall recovery was constructed as largely dependent on time and situational change. Aasha reflected:

I think time has been really useful, just to kind of think about things and growing up...

Moving out of home was a major stress reduction. I feel a lot more in control of my life and what I can do— I never had any of that growing up. I didn’t have any autonomy so for my personality in particular, I really need that… I’m very much my own person.

Similarly, Jared commented:

I think honestly moving might have just helped because I think a lot of the people around me weren’t really helping my mental state… it was a second fresh start and I think that actually really helped out quite a lot… I think some space from my parents also helped out a bit.

Jared also specifically positioned time and increased autonomy as being important to feeling better, saying: “having a bit of time to sort of be independent and learn how to do things… [I] just felt a lot better”. As demonstrated in Sam’s story, despite a change in circumstances, mental distress was not seen as being completely in the past. Jared explained that he still has “rough days” but copes better now. He also positioned “rough days” as a normal human experience and explained that he everyone he knows “could probably go to a psychologist and be a little bit better in their life because of it”.

These young people described feeling like they had developed the ability to cope more effectively with bad days or stressful life events than when they were younger.
However this personal growth was largely constructed as the result of a growing up and having more control over their lives, rather than as part of an explicit recovery narrative. The stories of the young people in this narrative type provided support for the argument that young people’s ability to exert agency and control over own their lives is compromised, and that this has potentially significant implications for their wellbeing (France & Threadgold; 2016; France, 2007). Like the “sensitive me” and “bad choices” narrative types, these three young people described feeling a significant sense of personal responsibility to look after themselves and “stay well”, but the notion of there being a silver lining to their difficult experiences was far less pronounced. Perhaps by locating the cause of their difficulties outside of themselves, these young people felt less need to redeem themselves or position their experiences as leading to profound personal growth.

The “Surviving the Chaos” Narrative

In this narrative type, experiences of mental health difficulties were constructed as emerging at a very young age in the context of family violence, addiction and abuse. Self-harm, substances and sex were described as ways to cope, but also led to distress being misinterpreted as “acting out”, which made matters worse. Recovery was described as a long, ongoing process of learning how to self soothe in non-harmful ways, which was influenced by positive relationships and getting away from negative ones. Through this process, young people described themselves as undergoing a dramatic transformation, describing themselves as being “completely different” in the present day. The two women whose stories illustrated this narrative type were Faye and Sarah.

Faye’s story
Faye described her first experience of “distress” as occurring in response to external events: the loss of her Grandmother at six, conflict between her parents and aggression from her father when he was drunk. Then when she was eight, she was sexually abused by a family member. She didn’t disclose what happened because she didn’t want to “stress family out”. Even though she didn’t really understand all these events Faye “definitely knew things weren’t quite right”. From a young age she had terrible nightmares and engaged in “self-punishment” behaviours— including sleeping naked on the floor under her bed if she was feeling guilty or not eating. When her parents separated at age ten, Faye moved towns and lived with her mother. She described becoming “enclosed” in herself while outwardly appearing extroverted and focused on helping others: “I felt like I was always trying to mitigate violence by being a people pleaser”. When she was 13, Faye’s mother remarried, to a man who was “a raging alcoholic”, leading to more stress at home. Around the same time, Faye started using drugs and alcohol: “As soon as I discovered alcohol and drugs it was definitely like a ‘yay—just another way to abuse myself’”. Her substance use intensified after she was raped by a family friend while “really, really drunk” when she was 14. She explained: “I went really into myself and just started using more. Just kept on getting into worse kind of situations and places”.

During this time, Faye’s distress and attempts to cope were misinterpreted as her “being a little bitch”. Her mother thought she had behavioural issues rather than mental health or addiction issues, and wanted to send her to boot camp. Faye was in contact with her GP but felt she was likely to relay information on to her mother, so didn’t feel she could trust her. Her mother attended GP appointments which also made it hard to open up. Faye also felt misunderstood by the adults who were meant to help her, and described how she was “more seen as a rebellious teenager than a distressed, traumatised young woman. It was really bizarre”. This sense of being misunderstood and not believed, a key theme in this
narrative type, could be understood as another form of abuse, because it stopped Faye getting the help she desperately needed. She explained: “You don’t get believed about things that are totally real. It’s like people within a position of power, whether it be parents or doctors, can make up your story based on what they believe and it’s just bullshit”.

There were a few instances when Faye felt people were on her side. She described interactions with a woman who worked at her local youth centre as being pivotal in helping her to trust people again:

There was me getting shit faced... [she] always said ‘you can come back–we can’t let you in you in right away when you have had alcohol’... So she was kind of like putting some boundaries on things but not excluding me because of how I was behaving at the time. She was really, really good.

She also talked about one of her school guidance counsellors, who supported her to develop practical strategies to survive living at home, and helped her devise a plan for leaving once she was legally able. This woman encouraged Faye to stay in education and suggested she might be good at working with people. Faye said that feeling like someone believed in her was “really, really important”.

Faye left home at 16 to live with her boyfriend Travis, who she described as her ticket out of the “mayhem” at home. Travis didn’t use substances and Faye had to stop using to be with him. She described this as leading to the emergence of her mental health issues: “that was the first time I was clean and then after six weeks of being clean, my mental health stuff really started to show”. Faye became very depressed, suicidal and was experiencing Post Traumatic Stress Disorder (PTSD) symptoms which had a big impact on her relationship and study. Her dependence on Travis started to get “unhealthy” and after two years together, they broke up. Although she went back to using drugs and alcohol after the
relationship ended, she described his stable, safe influence in her life for that period of time as important and as somewhat of a turning point for her.

When she was 17, Faye reached out to her GP for help with her PTSD symptoms. She remembered specifying that she needed someone she could speak to about “women’s issues”; however, she was told the only person she could see was a man, which she found really awkward. Her first session with him destabilised her and led her to start using substances again—she was so “pissed off” that she didn’t go back. Faye continued struggling with her symptoms and using substances to cope. She described it as a “weird kind of juggling balance between using drugs and alcohol and feeling pretty good—like medicating myself—to not using and kind of having PTSD type stuff”. She was retriggered often, even by healthcare professionals who she felt lacked an awareness of and sensitivity to trauma. However, after moving cities at 21, Faye started seeing a sexual abuse counsellor which helped her “understand some stuff more” and helped her to manage better. Through experience she has learnt what things can set her off, but commented that “it’s taken quite a while to find things that are soothing or whatever that aren’t harmful”. Faye completed university and at the time of interview was working in mental health. She described having an employer who had made a big effort to understand her “un-wellness” as being an important part of her ongoing recovery. A validating, understanding partner has also been very important, as well as having a regular rhythm to life—eating well, exercise and social connection.

Looking back, Faye wasn’t quite sure how she got through her experiences but was glad she did. She described feeling almost unrecognisable to the girl she used to be. Sometimes, she will tell her partner or a friend about her old life, and they don’t believe her because she is “so together” now. Faye positioned refraining from drugs and alcohol as an important part of her recovery, largely because it helped her to stay safe in a world where
“there are evil people everywhere”. Although Faye described herself as safer and healthier than she used to be, she also described a sense of loss for the old Faye:

I look back and I love the person that I used to be. Sometimes I was so outwardly energetic and although I was so traumatised and scared on the inside... I was spontaneous, I wasn’t afraid of things. That’s because I was using and was feeling really good about life....Sometimes I feel I’m so boring now. Like I have lost a whole part of myself.

Faye’s story exemplifies how in this narrative type, young people portrayed their mental distress as starting very early in life in the context of chaotic, volatile, unsafe environments. Sarah referred to herself as a “mentally ill child”, “a little bit odd” and “a very anxious child”, but also firmly contextualised this by saying “because of what was going on at home I was always in fight or flight”. She described how she was always aware of differences between her family and other peoples and described her dad as a “full blown alcoholic” and mum as “a junkie”. While Faye described coping at a young age by being becoming a people-pleaser, Sarah’s coping strategy led to her being bullied:

I lied a lot to get attention and that is totally what happens if you come from a neglectful family–you lie, lie, lie to get any sort of attention and so people didn’t really like me for that.

Sarah positioned her lying not as bad behaviour but rather as a normal response to the environment she was in. This theme of distress being misunderstood occurred throughout Sarah and Faye’s stories and was a major theme of this narrative type.

As Faye’s story demonstrated, drugs and alcohol were positioned as a way to “self-medicate” and self-soothe. Sarah said: “I was drinking consistently everyday... that was the way I coped yeah, and self-harm”. Sarah explained that she had never been taught any
“positive coping mechanisms” to help her deal with feelings of sadness or the flashbacks she had experienced since childhood, which she described as “boom, boom, boom like one after the other after the other. Like the worst kind of movie being played in your head”. Sarah said that substances and self-harm helped her “stop the movie”. While using substances was primarily a way to cope with the impact of trauma, it was also associated with some really positive experiences—such as meeting “lovely people” and feelings of confidence and spontaneity. However, both Sarah and Faye described their substance use as increasing vulnerability. Sarah said “I did get myself into a lot of trouble as well, by being too drunk and passing out in unsafe places…unsafe things happened”. This sentiment was echoed in Faye’s description of trauma experiences in the context of being “really, really drunk”.

Substance use was also positioned as detrimental because it contributed to distress being misunderstood as “bad” behaviour. Other coping strategies such as running away and being “promiscuous”, also led to these young people being labelled “rebellious” and subsequently punished, rather than supported. In a sense, these misunderstood cries for help represented another form of trauma and illustrate the lack of power young people have when authority figures interpret their behaviour as deviant behaviour. The experience of distress being misunderstood or considered “deviant” has been identified in adult recovery narratives that described “the problem” as developing out of experiences of abuse (Jacobson, 2001).

In contrast, experiences with adults who saw through the “acting out” and offered support, were described as pivotal and as playing a key role in recovery. Sarah described the transformational impact of being welcomed back by one of her foster mothers despite having called her names and run away: “No one has ever done that in my life, just been loving and been like ‘it’s okay, you fucked up’… it was a huge moment of my life... I changed completely—I wasn’t angry at everyone anymore”.

This quote echoes Faye’s sentiments about such experiences being profoundly healing. With relational traumas being described as underpinning participants’ distress in this narrative, feeling accepted, supported and believed (in) were constructed as playing a role in healing these wounds. Faye, in particular, described how positive relationships played a significant role in her recovery process. Having the support of a few key people who embraced her as she was, was described as making the difficult task of facing traumatic experiences and rebuilding her sense of self, more achievable. Similar to the “not me” narratives, having the ability to get out of harmful situations was also positioned as really important. For Sarah, this included leaving abusive and destructive relationships, both with romantic partners and her mother, who she ceased having contact with. Sarah described how in the absence of positive relationships in her life she learnt how to rely on herself, be her own friend and “support myself the way I wanted others to support me”. Sarah didn’t describe this as a choice so much as an act of desperation: “I wanted it so desperately from somebody else that I did it for myself”.

As described in Faye’s story, replacing substances and self-harm with safer ways to self-soothe was positioned as a crucial part of getting better but also a sense of loss. Sarah described it being incredibly difficult to try and socialise sober, because all of her self-confidence “came from booze”. Faye described wanting to be go out and have a few drinks like other people her age, but not being able to because it made her feel so vulnerable and unsafe, reflecting the ongoing sense of responsibility to keep oneself safe from others that was expressed in these stories. This “responsibility to keep safe” contrasts with the “responsibility to stay well” that was identified in the “sensitive me” and “bad choices” narrative. This need to keep oneself safe was described as extending to interactions with health care professionals, and both Sarah and Faye described being “more traumatised” by interactions with health professionals who weren’t sensitive to their experiences of trauma.
In this narrative type, young women described the process of getting well as transformational, and conveyed a sense that they had fundamentally changed. Sarah said:

I was such a mess. Looking back on it I am like, ‘whoa’. A lot of my friends are like ‘Sarah, how did you do it? What the hell? Who is this Sarah we are meeting now?’ Yeah, yeah. So it is kind of like they can see a completely different person. Like, Sarah at 16 and Sarah at 22 is two completely different human beings.

Sarah’s description of changing from a “a broken person” to being “more centred, more together”, reflects the idea that trauma can cause a “fracturing of the self” or “fragmented identity” (Harter, 1998; Herman, Perry, & Van der Kolk, 1989; Herman, 2015) as well as dominant ideas about a “healthy” identity being unitary and cohesive one (Erikson, 1963, 1968). Faye described going through a similar transformation, saying people saw her as “so together” now. However Faye described paying a price for this “togetherness”, namely the loss of the spontaneous, free part of herself who loved “living on the edge”:

What feels different? ...feeling like I have lost some of myself and my identity in getting well. Like, I really, I kind of grieve in a way for the person that I was because yeah, she was amazing. I nearly talk about her like she doesn’t exist anymore. I know she does.

This quote illustrates how, although overall the “surviving the chaos” narrative can be thought of as having a progressive “redemptive” quality (McAdams, 2001), a sense of loss also permeated these stories. Faye cried as she told me “I feel so boring now, like I have lost a whole part of myself”.

While both Sarah and Faye identified with diagnoses of PTSD, resistance to psychiatric discourse was evident in this narrative type. Faye talked about how she had been seeing a psychologist but had refrained from diagnoses because she didn’t “really believe in
them” and also feared that a diagnosis would lead to being treated with medication: “Oh you need to start taking Fluoxetine and Olanzapine” and it’s like ‘fuck off, no. I don’t want to. I’ve come this far without it’”. Faye described only using medication when it felt like a choice and positioned her focusing on therapy over medication as a “harder, longer kind of road” but one that would lead to a deeper type of “healing”. Sarah described strongly identifying with the diagnosis of complex PTSD which replaced an original diagnosis of Borderline Personality Disorder: “My personality isn’t disordered, I have just had a fucked up situation, you know?”

Sarah’s strong identification with a trauma-informed interpretation of her symptoms fits with the explanatory model of “the problem” in this narrative. Similar to the “not me” story, while Sarah and Faye both mentioned parental experience of mental health difficulties, these were not constructed as providing evidence for a biological predisposition to experience distress, but rather as providing environmental context. Also, although drugs and alcohol played a key role in these stories, using was not positioned as the result of naïve, risky choices, as it was in the “bad choices” stories, but rather as a survival strategy that masked mental health issues rather than causing them.

Despite the strongly environmental emphasis in this narrative type, young people were still left with the ultimate responsibility for getting better, staying well and keeping themselves safe. Although this responsibility was positioned as having a positive impact overall, parts of the self and lifestyle had to be sacrificed in the process. With the blame for the problem squarely located outside of themselves, there was little need for personal redemption through personal growth or work, and there was no evidence of the influence of “silver lining” narratives in Sarah’s and Faye’s accounts. However in this narrative type, “getting better” was described as coming at a cost of the complete transformation of the self, which was described with some ambivalence and a touch of longing for their younger
spontaneous selves. Importantly, this narrative type foregrounds the potential that dominant cultural narratives around “risky youth” (Kelly, 2000; Kelly, 2007) may hinder traumatised young people from getting the help they desperately need.

The “Product of the System” Narrative

The “product of the system” narrative was identified in only one participant’s story. Lucy, who was in her mid-twenties when interviewed, was different from the other young people in the study in that she had lived with a diagnosis and taken medication for as long as she could remember. Lucy appeared to still be in the process of forming a coherent narrative around the primary cause of her mental health difficulties; however, she positioned her lifelong interactions with “the system” as potentially contributing to the development of further problems. Lucy constructed her identity as heavily influenced by medication and interactions with mental health professionals, leading to a sense that she was a “product” of the mental health system.

Lucy’s story

“I don’t remember my diagnosis being given to me” Lucy started off. She was diagnosed with Attention Deficit-Hyperactivity Disorder (ADHD) and put on Ritalin at age two, and had been seeing psychiatrists and psychologists ever since. Lucy remembers many occasions of being tested and observed by “strange men in suits” and wanting to impress them and “be a good girl”. Overall, Lucy felt her childhood had been a happy time although she did remember “feeling bad” about not being able to control her emotions. Although at the time she didn’t understand she had ADHD, she always knew there was something “different” about her. She used to ask her parents why she was different but they never had any answers. This lack of explanation seemed significant to Lucy and was identified as a
reoccurring theme throughout her story. Lucy also constructed taking medication from a young age as having a profound impact on her identity growing up, describing how when she was upset she would say things to her parents like “you don’t love me without the pills”.

Lucy identified a stressful period of transition as exacerbating her psychological distress. When Lucy was 12 years old, her family moved to New Zealand. Lucy found it difficult to fit in and said “everything went downhill” after they arrived. Finding it hard to make friends, she started drinking, using drugs and having sex—“going against all my morals” to fit in. Lucy said that during her “experimentation” phase she stayed clear of harder drugs due to being told by a psychiatrist that she had “an addictive personality”—an assessment she agreed with. This psychiatrist gave her a lot of “very direct advice” which made her worry about her future: “I remember saying to my mum afterwards ‘he makes out as though I am going to become a stripper on crack or something if I don’t follow his advice’”.

Lucy’s efforts to fit in ended up making things worse—she was bullied by multiple people and felt like an “outcast”. Looking back, Lucy wasn’t sure how she got through this but did say she had been more resilient at that time of her life: “I was really, really strong during the bullying at school. I just don’t know how I managed through that because if that were to happen to me now then I wouldn’t be able to cope”. Around the same time her parents got divorced. This added to her difficulties and soon after Lucy experienced her “first episode of depression and OCD”. She described having intrusive thoughts and panic attacks where she would pass out, which was “very, very, very scary”. At this stage she was “introduced to more medication” and saw a psychologist for about a year at her local CAMHS. Lucy described her treatment at this time as being good. Her psychologist told her she couldn’t experiment with sex and drugs while on so many psychiatric medications, so she stopped.
Around this time, Lucy decided that “enough was enough” and that she needed to change her life. This included secretly stopping Ritalin. She had noticed that when she missed her medication she “really, really enjoyed the happy go lucky Lucy”, in comparison to feeling like she was “in a bubble” when she did take it. She didn’t tell her parents or doctors because she knew they would panic. When she gained university entrance without taking Ritalin for over a year, she finally told her family and doctors, who said she must have grown out of her ADHD. Lucy described secretly stopping Ritalin as one of the best decisions she had ever made. It appeared to mark an important moment for Lucy and one of her first attempts to take control of her body, mental health and sense of self.

The impact of her ADHD diagnosis lingered: Lucy chose to get a job instead of going of university because she wanted to “make sure” she didn’t have ADHD before continuing with study. This went well until she experienced workplace bullying at age 20. This triggered a lot of psychological distress and suicidal thoughts. Lucy reached out to mental health services and was diagnosed with anxiety and depression. She described psychiatric diagnoses as having a significant impact on her sense of self, saying that they made her “feel more depressed and more anxious and more hopeless... I hate labels, I hate them with a vengeance. They are just horrible because they can make a person completely feel different about themselves.”

After another major crisis during which she tried to end her life, Lucy spent some time at a peer-led respite service. This contributed to her deciding that she wanted to work in mental health so she could “help people going through what I have been through all my life”. Lucy described this as an important turning point for her: “I just one day decided that I can’t keep living a life where I have my mental illness controlling my life”. She started studying and working in peer support and described setting goals as an important part of getting better. Lucy conveyed a real sense of responsibility for her own recovery: “no one else is
going to do it for me, I have to do it for myself”. For Lucy, recovery was “living a normal life”. She described herself as the healthiest she had ever been and largely attributed this to her psychiatrist getting her “medication down to a tee”. Lucy described feeling stuck between longing to discover who she was without medication while also being “too scared to find out”:

I would really like to one day be able to use my coping strategies and be medication free, because I am a product of the mental health system. I have been on psychiatric medication since I was two years old. My blood is pumped with psychiatric medication. I don’t know who I am without psychiatric medication. I’ve only been someone without psychiatric medication for two years of my life. Who is the real Lucy? No one knows...

This quote illustrates the significance Lucy puts on her life-long interactions with the mental system, and how this has impacted her ability to discover who she really is. Looking back, Lucy described feeling upset and angry that she was put on “such a harsh medication” at such a young age and that “people tried to mask who I was with the pills”. She reported having the scary thought that she was put on Ritalin by mistake and that being on it for so long had made her who she is today. When doctors recently suggested that she may have had bi-polar disorder instead of ADHD she “freaked out” about the possibility that “they had it wrong the whole time”. Lucy also described a sense that mental health services had run out of ways to support her and didn’t really know what was wrong with her. Despite developing coping skills through her contact with mental health professionals, Lucy described feeling weaker and more sensitive than she used to be and felt she now needed “some type of therapy to stop being sensitive”.

Unlike the other narratives that attributed “being different” to innate sensitivity, poor choices or environmental factors, it was difficult to identify a clear explanation in Lucy’s
story, although her interactions with “the system” had clearly signified she was different from a young age. Although Lucy constructed her move to New Zealand and related social pressures as triggering some of her difficulties, her ongoing “search for understanding” was identified as a key theme in her narrative. Lucy described her childhood as relatively happy, which seemed to add to the confusion:

I remember my best times of my life were when I was a young age, so I don’t know why I was put on pills. I don’t know how you put a two year old on Ritalin. I don’t understand…

Being too young to have any memories of the process appeared to contribute to this confusion, as was the fact that her parents didn’t offer an explanation either. As she got older, Lucy described engaging in an active process of trying to understand her experiences and explained:

I have every single psychiatric report from when I was two years old. I have read two of them and I had to stop because I got angry... like, how do you diagnose someone with ADHD because of these simple things? ...I just looked at the report going ‘how do you get someone with ADHD from this?’

Rather than providing answers, these reports were described as adding to her sense of confusion and feelings of anger. The absence of a clear causal explanation and subsequent “search for understanding” highlights the general trend identified in this study of young people to emphasise the importance of “understanding” and making sense of out difficult life experiences (McAdams, 2006; Pals, 2006)

Lucy’s story conveyed a sense that her lifelong involvement with “the system” had had a profound impact on her. Throughout her story she explicitly described feeling like she had never really “known” herself without medication or a diagnosis. As a very young child,
her frequent trips to be assessed, and reminders to take medication at school, alerted her (and others) to the fact that she was “different”. While some of the young people in this study largely resisted ideas from professionals who pathologised their personality or behaviour, Lucy appeared to agree with her doctor’s assessment that that her personality was “addictive” and worried about how she might “turn out” if she didn’t follow his directive advice. Lucy’s description of diagnoses having the ability to “make a person completely different” illustrated her construction of doctors as possessing the power to define “who” she was and “treat her” accordingly. Lucy’s account appears to offer weight to the suggestion that diagnostic labelling may have a significant impact on young peoples’ sense of self and identity (Ward, 2014).

For Lucy, taking medication for her whole life was not only constructed as signifying her “difference” but also as representing that she had never been fully accepted in her own right. Her sense that medication was used to change who she was, appeared to generate one of the key tasks of this narrative type–finding out who she “really is”. This search for the authentic self has been described by Guignon (2004) as the “project of becoming the person you are” (pg. 2). For Lucy, coming off Ritalin appeared to provide an opportunity to “find” or “be” her authentic self, albeit for a short period of time: “I prefer myself without the Ritalin because that is the true me, not a chemical version of me”.

However, later in her story Lucy conceded that she was still a “chemical version” of herself due to taking antidepressants and mood stabilisers. The ways she described this was characterised by inconsistency–on one hand she appeared to normalise her antidepressant use as “just like people who have problems with diabetes” whilst also positioning these medications as the primary barrier to her quest for authenticity: “I don’t know who I am without psychiatric medication...Who is the real Lucy? No one knows”. Similar concerns about the impact of anti-depressants on authenticity have been identified in existing literature
(Malpass et al., 2009) and often found to be associated with decisions to cease treatment. However, Lucy’s concerns about whether she “will be able to come off them” appeared to hold her back from taking such a step: “I don’t know who I am without psychiatric medication and I am too scared to find out”. While Lucy’s preoccupation with identity is not considered unusual for young people living in contemporary western societies (Baumeister & Muraven, 1996), her longstanding interactions with “the system” appeared to contributing to the significance of this process for Lucy.

Throughout her story, Lucy described attempts to exert agency and control over her health and wellbeing: deciding to stop experimenting with substances, deciding to stop Ritalin, and deciding to stop letting her mental health issues control her life. Although still a sense of forward progression in this narrative, it was less pronounced than in some other narratives and was mixed in with a significant sense of loss, sadness and confusion. In contrast to some other young people who constructed themselves as becoming “stronger” or “wiser”, Lucy constructed herself as becoming more sensitive and less strong over time. She reflected back on experiences she had when she was younger and described how she felt she would be unable to cope if faced with the same situation now:

I didn’t have many skills, techniques and coping strategies at that time but I was a lot stronger person then, I wasn’t so sensitive. I used to be a really hard case, I used to have a really thick skin and something ripped off the thick skin. I don’t know what that was.

Whilst Lucy identified her present day self as “someone who is very sensitive”, this was not positioned as a virtue, but rather a target for self-improvement: “I have mentioned to my psychiatrist on many occasions that I need some type of therapy to stop being sensitive”. In this way, the “product of the system” narrative type rejects cultural narratives about there
being “silver linings” from difficult experiences or the sense that “what doesn’t kill you makes you stronger”. Like other young people in the study, Lucy described an overriding sense of personal responsibility for getting well. She strongly positioned the “responsibility” of changing her life as residing within herself: “no one else is going to do it for me I have to do it for myself” and went on to describe how taking personal responsibility for one’s mental health is a part of recovery more generally:

I think that a lot of people in mental health system rely too much on other people for things and they really need to stop that attitude…People can’t do the work for you

Although identity was a key theme in all five narrative types, the impact of psychiatric diagnoses and medication on identity appeared most profound in Lucy’s story. Lucy’s narrative also seemed to lack clarity around the fundamental cause of her distress, as did her description of recovery to some extent, which centred around the more general ideas of living a “normal” life and being medication free. At the conclusion of her story, there was a strong sense that Lucy was still grappling with how to overcome her mental health challenges. This may in part have reflected the lack of causal explanation to guide more specific recovery tasks, and also that the system designed to support her with this process, appeared to be implicated in her difficulties.

**Summary**

The analysis presented in this chapter was concerned with the way in which young people make sense of their personal experiences of mental health difficulties and recovery. It was focused on understanding each participant’s account as a whole, both in terms of plot or overall message, as well as key themes and narrative tone. The analysis identified that these
young people described the process of recovering from significant experience of mental
distress as extremely personal and self-directed. Five narrative types were identified to
capture the main differences in how young people storied their experiences. This typology
was largely based on variation in how young people conceptualised the cause of their mental
health difficulties. This conceptualisation appeared to lay out the path to getting better and
also influence how young people described the impact of their experiences on their identity.
Other themes commonly associated with recovery such as agency, connection, hope and
meaning were also identified in these stories, albeit manifesting in different ways. The
influence of wider cultural discourses was also foregrounded for each narrative type, as well
as some of the ways each type of story may have both helped and hindered these young
people.
Chapter Five: Thematic Analysis
the Role of Professional Support in Recovery

The narrative analysis identified that overall, young people described the process of recovery as an extremely personal and self-driven journey. However, they also positioned interactions with professionals and services as being relevant to their story: all of the young people in the study talked about contact with mental health professionals or services and some also described their interactions with GPs, school guidance counsellors and other professionals. Narrative analysis is interested in stories as a whole and, although there were some exceptions, the way that young people described their interactions with services was not identified as a core component of the recovery narrative typology described in the previous section. Thematic analysis offered a method to identify, analyse and interpret common themes and ideas that were identified across participants’ stories. A thematic analysis was conducted to explore how young people understood and described their interactions with professionals and services, in relation to their recovery process. The themes identified during this analytic process are described in this chapter, which is split into five parts: Struggling with Services; The Human Relationship; The Impact of Interventions; Personal Agency and Engagement, and Helping Others: Working on the Other Side.

Struggling with Services

Overall, young people described having difficulty accessing and engaging with services. This was most commonly discussed in regards to the mental health system, but also extended to the health system more broadly and other social services. The following three themes encapsulated the way young people described their interactions with services as a whole.
They aren’t there when you need them.

Many young people described feeling that at some point during their recovery journey, they didn’t get the support they needed from services. This lack of support was described as occurring at multiple points of engagement—from initial stages of trying to access help, all the way through to being discharged.

Accessing services was described as challenging by several young people. Sam disclosed suicidal thoughts to the family GP and was told they would be referred to mental health services (MHS). However, no one ever contacted Sam and, a few weeks later, the doctor suggested the referral must have “got lost in the system”. Sam reported pulling through this period of crisis but described the experience as “frustrating, because, you know, I was supposed to get help… it is not great for trusting the health system.” Vijay also spoke about it being difficult to get help from services:

Called the Mental Health Line, just talked to them and then they couldn’t do anything. They didn’t actually do anything at all. The only way they would help me was if I say, “I’m going to kill this person. I’m going to hurt myself”…There’s really never any support for anyone unless they go to ED or something like that.

Vijay was one of a number of young people, who described first becoming involved with mental health services in the context of a crisis. In his case, this was when he overdosed at school. When asked what he thought of the services he subsequently used, he said:

They’re all shit…The staff were mean, they don’t even support you. The food was terrible. There’s nothing to do and you feel like you’re going in a cycle… I’d go out for six weeks and go back in for another six weeks; go back in for six weeks, go out for six weeks…constantly in there.

Vijay described dropping out of high school because it was too difficult to keep up with his academic studies, highlighting some of the potential wider ramifications for young people in
this situation. The “cycle” that Vijay described was similar to Isieli’s description of his early contact with a mental health service. Isieli explained, “It was pretty much like a repetitive kind of thing for me ‘cause I didn’t really find that sort of help that I needed”. Both Isieli and Vijay described their care as being characterised by recurring periods of hospitalisation, which ultimately led them to feeling hopeless and suicidal. Many of the young people who talked about using inpatient services described them as being necessary for safety reasons, but not facilitating recovery or healing.

Even after being accepted into services, several young people described feeling like they were “lost to the system” or had to be in crisis to get the care they needed. Kalena described feeling as though she wasn’t followed up enough after being discharged from her first hospital admission saying, “I think they saw me once a week… [it] wasn’t enough, not for someone that young that is so brand new to the system”. Aasha and Lucy spoke about difficulties in accessing psychological therapy as part of their treatment under community mental health services. Lucy said, “the waiting list needs to be shorter, I have been on the waiting list for some therapy for a very long time now”. Likewise, Aasha recalled:

They kept telling me there was a huge waiting list, which is really difficult to hear ‘cause you’re like, ‘What do I do in the meantime?’ …I felt like they didn’t really take me very seriously and I needed to do something really drastic to get up the waiting list.

Sarah, who in addition to using mental health services, was under the care of a child welfare service (Child Youth and Family Services: CYFS) described her experiences with the agency as “extremely unhelpful”:

CYFs have been pretty shit… Yeah, um in the long and the short of it, they didn’t help me reconnect with my family. My family and I are completely disconnected… I think that is one huge downfall that CYFs, you know, that was their responsibility and they
did not do it. Um yeah. That’s one thing. Oh there are many others things–like the following up about sexual abuse, they never did that and I feel like they probably should have.

These quotes illustrate the sense of disappointment and feelings of being let down by services that many young people expressed at various points of their story. Even Jared, who described having positive experiences with services overall, said he “fell out of the system” when he was discharged, despite still needing help. The experiences they describe seem to mirror the findings of existing youth perspectives literature that suggests young people find it difficult to access services (Buston, 2002; Houle et al., 2013; Lavis & Hewson, 2011; McCann & Lubman 2012; Summerhurst et al., 2017). Concerns about young people needing to be in crisis before being able to access mental health services in New Zealand have also been raised numerous times in the past two decades (Barnett & Lapsley, 2006; Mental Health Commission, 2006, 2011). Overall, young people in this study tended to describe progressing through a process of recovery despite their experiences with the mental health system, rather than because of them.

**Services are not set up for people our age.**

Several young people specifically spoke about the care they received not being well matched to their age. Chris and Vijay described feeling as though they were treated as much younger than they actually were during inpatient stays. Vijay said he was “treated so much like a 12-year-old when I was 16–I didn’t expect that.” Chris, whose admissions were to adult inpatient units, commented that, “getting treated like a kid was the worst thing. Like bed time and lights out”. In contrast, Kalena spoke about feeling as though her experience in an adult mental health inpatient unit at age 17, was not suited to her age for the opposite reason:
I suppose going through the system at that age, I was really scared. Like you go into this hospital and there is people doing weird stuff, like I haven’t really been exposed to a lot of that and then I get in there and I am like 17 years old… men in there that are doing really gross, yucky things… it was frightening being in there.

Kalena could only remember one time when a nurse sat down with her to ask how she was doing. Sarah also described not receiving the support she felt someone of her age needed from a child welfare service (CYFs):

Coming out of CYFs care was pretty intense. Like, they kind of just, like kick you out—see you later, good luck sort of thing and I needed a little more support than that. Normal 17 year olds don’t move out at 17–it is not a normal way to move out.

Kalena and Sarah both seem to imply that at 17, they were in need of more intensive support than that they were provided with. Yet the earlier quotes highlight the need for support to be provided in such a way that it helps young people maintain some sense of autonomy—even if just in regards to the structure of their day or bed time. Understandably, not “being treated like a child” during interactions with health services has been identified in existing literature as important to young people (Buston, 2002; Freake et al., 2007; Harper et al., 2014). In general, young people seemed to highlight that for care to be helpful and supportive of the recovery process, it needs to be matched to their developmental needs.

**It’s confusing to negotiate services.**

Several young people spoke about experiencing difficulties during initial stages of engagement with mental health services, while others described some of the challenges associated with being involved with multiple services at the same time. Some young people
described feeling confused by the referral process, like Aasha, who was referred to mental health services at age 16 by her school guidance counsellor:

So I went there [the CAMHS], didn’t really understand why I had to go to the [school] counsellor and then go there. Like it didn’t click with me and I don’t think it was really explained why the counsellor couldn’t do the work.

Aasha described how after she had “confessed” what was going on for her to her counsellor, she had to re-tell her story to multiple people during the referral and assessment process, explaining, “it was like three different people and that was very intimidating for me… my mother was there as well um and… I hadn’t really openly discussed it with my mum”. The use of the word confessed suggests that the information she was being asked to share felt extremely private to Aasha. When describing her experience of using adult services later in life, Aasha said, “it was again kind of the same story around… I think within the first three appointments I saw six different people”. Isieli described a similar experience during his initial contact with mental health service, saying, “every time I see someone, it is always a different person” and described dealing with “heaps of teams”.

Young people also spoke about being put off by being informed they were eligible for a specific number of therapy sessions. Aasha recollected being told she could have 12 weeks of therapy and thinking, “well, that’s not enough. I’ve been this way for years and you’re telling me 12 weeks is all I get?” Faye described a similar feeling when told by multiple GPs from the age of 14 that she could get “6 sessions” with a counsellor. She explained feeling like, “who is to say that in six sessions I am going to even be able to build enough of a relationship with a person to even begin to talk about this kind of shit? That always really fucked me off”. These quotes suggest that 6 or 12 sessions did not seem like enough time to get to know someone well enough to disclose personal information, and perhaps also seemed
to invalidate their experience of prolonged and painful mental distress. Faye described that the six session offer put her off pursuing therapy for a number of years.

Some of the young people in the study used multiple services at one time and described how the lack of integration between different services impacted their mental health. Kalena explained how a residential drug and alcohol programme she wanted to attend didn’t accept people on psychiatric medication, so she was signed off by a doctor as being well enough to come off her medication, however “within two weeks of being there I was in full blown psychosis again.” Vijay described being admitted back to hospital after a period in a residential drug and alcohol facility: “I was unwell in rehab but they wouldn’t send me to hospital and I didn’t want to go because if I had gone, I lose my level and I was at level three and one stage away from graduating”.

Overall, young people highlighted how some of the processes and procedures implemented by services in New Zealand made it harder for them to effectively use services, to support their recovery. The practise of having different clinicians performing triage, assessment and intervention duties is not uncommon in the New Zealand mental health system, nor is having parents being involved during initial assessments in CAMHS settings (York, 2017). However, existing research indicates that young people have particular concerns about both retelling their difficulties to multiple people, and having their parents involved in sessions (Day et al., 2006; Harper et al., 2014; Persson et al., 2017; Strickland-Clark et al., 2000). The need for time to feel comfortable enough to disclose, has also been identified in previous youth research (Hartzell et al., 2009; Lavis & Hewson, 2011; Lindgren et al., 2014; Persson et al., 2017). The accounts of young people in this study mirror existing New Zealand findings relating to barriers to optimal care for co-morbid substance and mental health issues in New Zealand (Todd, Sellman & Robertson, 2002).
The Human Relationship

All of the young people in this study also described their interactions with specific professionals, and in doing so, strongly emphasised the importance of a good relationship for professional support to feel helpful. Young people described, both explicitly and implicitly, the types of personal attributes and relationship dynamics they found supportive of recovery—and those they did not.

It’s good if they “get it”.

Many young people emphasised how feeling understood, validated and believed by professionals was extremely helpful and played a role in their recovery process. Sam described how feeling validated and believed by their therapist helped to, “build up my trust in my own perceptions of things”. Faye described the importance of her guidance counsellor not only believing her version of what she was going through, but also believing in her:

She was like, “you need to, if you can, continue some kind of education. Maybe social work or counselling isn’t a bad option for you. I think you would be quite good at it. I think you are quite in-tune with people and stuff”.

Faye took the guidance counsellor’s advice, subsequently completing university and working in mental health—something she described feeling very grateful for. Jayita described her most useful interaction with a professional being with her personal trainer, who really “got” how to motivate her. Other young people, including Sam and Aasha, described how professionals who really understood them and the nature of the problems they were facing, were more able to provide useful interventions.

Conversely, young people described having very negative experiences with professionals who they felt did not really listen or were not genuinely interested in understanding them. Chris spoke about a one-off interaction with a doctor who he felt just
“made assumptions” about him after reading his clinical file, and how this lead the doctor to prescribe a medication that, “didn’t even make a difference”. Chris said, “he could have learned a lot more by having a better conversation with us” and described the longer term impact of this experience by saying:

I guess that doctor made me feel like I was going backwards, not in a sense I was getting more unwell but in a sense [slight laughter] that the world was moving backwards, back to the time when I felt like a patient… he didn’t really upset me but discouraged us a little bit from that clinical perspective.

Young people also described feeling like clinicians did not “get” them because they were insensitive to their specific needs. This was most often spoken about in relation to complex family dynamics, co-morbid substance issues and trauma histories. Aasha described how her therapist’s “CBT” focus on “changing her thoughts” and “personal responsibility” was insulting and failed to acknowledge the impact of her father’s physical and verbal abuse. Aasha was one of several young people who described feeling invalidated and at times unsafe, when working with professionals who were not adequately sensitive to their trauma history. This often led to disengagement from treatment despite feeling desperate for help.

Young people explicitly labelled feeling understood and as though clinicians “got” them and their problems, as a key component of helpful treatment. This also appeared to contribute to whether an intervention felt relevant and useful. Feeling understood, believed and respected by clinicians has been highlighted as important to young people by previous studies (Binder et al., 2011).

They must be genuine.

Young people often described positive interactions with professionals as feeling “genuine” and as being characterised by mutuality, connection and warmth. They also used
phrases like “getting on really well” and described being able to “relate” to some professionals more than others. Sometimes characteristics such as age, gender and culture were described as facilitating this process of relating. Chris spoke about one of his most positive relationships as being with his Community Support Worker (CSW) Dan, whom he described as being similar to him:

He was a lot like me. He was musical, not very old, same interests. It’s just like having a buddy, like just a friend… it felt like a balanced relationship. As soon as it starts getting power imbalance it’s going to not be mutual any longer… having a CSW was probably the most constructive thing to my recovery.

Similarly, Jayita described age as relevant to her most helpful relationship with a professional:

I kept seeing people who were older than me. Um I don’t think that is very helpful. ‘Cause the only person who really did help me get through all this stuff was my personal trainer, life-coach person….she was also around my age.

Isieli described his keyworker’s warm, gentle interpersonal style as helping him to engage more genuinely with other clinicians and “get serious” about his treatment. In contrast, many negative experiences were described as lacking warmth, empathy or genuine connection. Aasha referred to one, “awful psychiatrist” as a, “very robotic woman”, Chris referred to a psychiatrist he didn’t like as, “very clinical”, and making him, “feel like a patient”, and Kalena talked about negative experiences with clinicians who had, “lost touch with human emotion”.

Unsurprisingly, losing a relationship with a professional after building a strong connection was described as difficult, as Sarah’s anecdote about dropping out of therapy illustrates:
She retired so I just didn’t go back and I kind of wish I had continued with it, but I built up such a connection with the person that I didn’t want to build that connection with a person again you know, so I just didn’t go back.

The way Sarah explained this experience seems to fit with existing youth research that suggests young people can find the end of therapeutic relationships difficult (Buston, 2002; Harper et al., 2014; Lindgren et al., 2014). In general, young people described a genuine connection as being an aspect of their most helpful relationships with professionals. As well as being experienced as subjectively positive, a genuine connection was also described as helping to foster engagement with a wider service. Existing research in this area has identified that young people tend to want relationships with mental health professionals to feel genuine and equal (Buston, 2002; Gibson et al., 2016; Persson et al., 2017).

They need to be there for you.

Young people also described the importance of feeling that a professional could be counted on to be “there” for them—both emotionally and physically. Faye recalled with warmth how her school guidance counsellor had looked out for her, saying “she had kind of been like, not spying on me, but keeping tabs on me”. Chris and Kalena said that at times, the most useful thing for them was just someone physically being there with them, rather than actively trying to help. Kalena explained how after being discharged from hospital once, her Peer Support Worker (PSW) visited her at home and said, “I just remember her being there and being with me was really good…just engagement, just human interaction, um from nice people. It was really big”. In contrast to these positive experiences, Aasha positioned her first therapist’s unreliability and inability to be there for her, as one of the key reasons she found that experience of therapy so unhelpful and dropped out.
Young people described often feeling isolated and alone during periods of their journey, especially when experiencing acute distress. While some felt they had the support of their family, many didn’t, or at least didn’t feel able to reach out and let their family know how much they were struggling. Several young people also described feeling as though friends and peers may have wanted to help but didn’t know how, which further contributed to a sense of isolation and feeling like they had to cope alone. In this context, it is understandable that young people positioned consistency, reliability and physical presence of a supportive person as a particularly helpful aspect of care. This fits existing New Zealand youth research (Gibson et al., 2016).

It’s a two way process.

Self-disclosure, done well, was described as one of the things professionals could do to help cultivate a warm, genuine connection with young people. Charlotte described having a preference for counsellors or therapists that shared a bit about themselves saying, “the people I tend to really like, you know they are quite warm and they share a little bit about their lives as well, so it feels a little more two way”. Jayita described a similar sentiment when explaining that her connection with her personal trainer was stronger because of the “two way” nature of their relationship:

It is a conversation and she can add in her stuff, but with counsellors, they can’t really add in their stuff too much. Yeah, yeah. Just like ‘this is what is going on in my life’ kind of stuff. They can’t really add that in so I guess it is a bond with her.

Chris talked at length about the positive impact of his “really good psychiatrist”, disclosing that he (like Chris) also had a diagnosis of bi-polar. Chris remembered thinking “whoa, great!” and explained that, “having someone that is clinical but also knows, you know
that they know. It’s like a validity thing and a genuineness, genuineness, yeah of care and compassion I guess”. Chris positioned this “good psychiatrist” as very different to some other clinicians who, “were basically just doing their job unfortunately, they are seeing patients symptoms as illnesses and medication as cures really, or manageable, a way to manage and my psychiatrist isn’t really like that”.

Nonetheless, young people’s accounts highlighted that not all self-disclosure was to be helpful. When Aasha described a positive experience of self-disclosure she said, “the way he disclosed it was really awesome as well. Some people over disclose but he did it in a really good way. I felt connected to a therapist for the first time in my life”. Lucy explained how one of her therapists used self-disclosure in a way that created distance between them, rather than bringing them closer:

That course of CBT wasn’t very helpful with the person that I did it with um because [pause] she was a young female who did the CBT with me and when she was running through the thought process with me she used to do it with her personal life but in a positive thought process, not a negative way and so it just didn’t work for me because she made me feel very intimidated.

So while young people described self-disclosure having the potential to signal that a professional had the capacity to genuinely understand and care for them, Lucy’s comments highlight the importance of this strategy being executed with care, and that misjudged self-disclosure has the potential to damage the relationship and impact treatment engagement. The views expressed by young people support recent suggestions that specific types of self-disclosure are associated with positive therapeutic outcomes (Henretty & Levitt, 2010; Levitt et al., 2016) and can be supportive of recovery.
The Impact of Interventions

While overall, young people spoke about services being difficult to engage with, and emphasised the importance of relationships, they also talked about the impact of the various interventions they experienced during contact with mental health services. The following themes describe the interventions that were talked about most often—diagnoses, medication, therapy and peer support.

A diagnosis can change things.

For 10 out of the 12 young people in the study, engaging with mental health services led to being officially diagnosed with a mental disorder. Several participants described diagnoses or “labels” as having a profound impact on their identity. Lucy said diagnoses had the power to make someone feel “completely different about themselves”, while Chris described how getting a diagnosis at a “transitory age” felt like “the rug was pulled out” from under his feet. Despite feeling well supported, receiving a diagnosis of bi-polar led him to feel alone and isolated at times:

I guess it’s different [compared to other adverse experiences] when you are going through an experience defined by a word or defined by a–like bipolar. It’s easy to feel like “I don’t know anyone else with bipolar, it’s just me”.

Some young people spoke about how the impact of a diagnosis could differ depending on contextual factors. Faye and Chris both spoke about feeling lucky that they didn’t receive a diagnosis or label when they were younger. Chris thought it would have been harder if he had been diagnosed at high school, rather than while at university. Faye, who spoke at length about some of the negative consequences of not getting the help she needed when she was younger, also described her mother’s reluctance for her to engage with CAMHS as sparing her from the potential negative impact of receiving a diagnosis early on:
Had mum of taken me to CAMHS, I think things would have been a lot different. I think I would have had a label a lot younger where I don’t know if that would have served me that well… I feel like it has buffered some of the things, the institutional discrimination and stuff, that might have happened, where I was able to get myself to a place of you know more privilege I guess around getting a degree and becoming an educated woman.

Faye seems to imply that the stigma associated with a mental health diagnosis may have limited her opportunities and jeopardised her ability to pursue tertiary education, and thus that diagnoses are more “dangerous” at a younger age.

Some young people also spoke about how receiving multiple diagnoses led them to feel as though mental health services, “didn’t know what to do with them”. Vijay said “it was Psychosis, then they moved into Bipolar, then Bipolar and Psychosis. Then Mood Disorder, yeah. When I got to adult services, it was just like, ‘We don’t even know what’s wrong with him’”.

Personality disorders, and Borderline Personality Disorder (BPD) in particular, were positioned as a particularly powerful and undesirable diagnosis. When it was suggested to Aasha during an initial assessment that she may have “borderline traits” she described it as “horrible because I knew the stigma that came with women in particular with borderline personality disorder”. Sarah said that when diagnosed with BPD at age 14 she thought “wow, that is really not me”. When asked what she understood BPD to mean at the time, Sarah said, “I don’t remember it being explained apart from like it could get me into trouble, I could get myself into trouble with this”. When she was 19, Sarah’s diagnosis was changed to complex-Post-Traumatic Stress Disorder (C-PTSD) which in contrast she felt, “hit the nail on the head”. Of her original diagnosis she said:
I have grown as a person since then. I was only 14. I don’t actually know if they should be diagnosing people with borderline personality disorder at 14 years old. Of course you are going to be unstable—you are 14!

Sarah’s description of C-PTSD feeling “right” for her (and validating that her distress was related to being in an “abnormal situation” characterised by chronic neglect, abuse and instability) illustrates how diagnoses were sometimes positioned as helpful. Charlotte recalled feeling “relief” when diagnosed with depression at age 14:

I remember thinking it was like the Santa Claus kind of thing where actually adult life just sucked and felt awful and no one actually told you that. So when I found out that actually I was sick I was like “oh thank God”. It was really quite a relief.

Young people also described finding ways to try and cope with the stigma associated with their diagnosis. Kalena described there being “a lot of stigma attached to schizophrenia” and said, “I like challenging that stuff… I do feel like it is sort of my duty to somehow change people’s perceptions or give them a little bit more understanding around it”. Chris recalled how reading the memoir *An Unquiet Mind*—about a woman with bi-polar—helped him to feel less alone. He also described finding it helpful to see ex-*All Black* John Kirwan talk about his own experience of depression, while still working as a sports commentator. To Chris, Kirwan appeared to represent a successful person neither “hiding” nor “defined” by their diagnosis. Similarly, Vijay reported that it, “gave him hope” knowing that celebrities he looked up to—including boxer Mike Tyson and rapper TI—had mental health diagnoses “like him”.

This theme provides insight into how young people experienced receiving and living with a mental health diagnosis from a young age. Overall, diagnoses were described as being significant and something that could both support or hinder recovery, depending on the individual and the type of diagnosis. In various ways, participants seemed to imply that
diagnoses may have more of an impact on young people than older adults, and largely spoke about this in relation to stigma. This fits with literature that indicates that many young people with mental health issues report experiencing stigma and discrimination (Moses, 2010b). However, some young people described diagnoses in a more positive light, consistent with existing literature that indicates that diagnostic language can be therapeutic for some (Wykes & Callard, 2010).

**Pills work for some.**

A majority of young people talked about their interactions with services resulting in being prescribed medication. Several participants described going through an extended process of trial and error to find the right (combination) of medication, but feeling like it was worth it in the end. Sarah said:

> The trial and error with the antidepressants was horrible. Like I just gave up on the whole thing. I was like ‘there is never ever going to be any medication that is going to help me. I have tried like 4 now and none of them have done anything’… yeah, I lost faith hugely and I just stopped taking medication.

However after a relationship break up Sarah decided to medication again, with much more positive results: “it just like changed my whole life. I felt better than before, yeah so I asked to continue them and they let me which was really cool”. Sarah’s description of medication as “life-changing” exemplifies how several young people spoke about medication. Kalena described going through a process of trying multiple anti-psychotics and dealing with unwanted side effects before she “finally found a medication that works for me and I think that has been huge, that’s been really, really huge”. She explained that her current medication, “has got some side effects but it is managed. My side effects are managed by another medication that sort of counteracts the side effects… [and] my body sort of built a
tolerance for it”. Kalena however acknowledged that medication doesn’t work as well for others and her voice broke as she said, “there has been times over the years where I really have cried and just been like ‘Why, why, why am I so lucky? Why have I been given a second chance?’”

Some of the young people who positioned medication as part of their long-term recovery expressed concern about “anti-medication” rhetoric. Kalena described it as irresponsible and dangerous for people to push their “anti-medication” ideas onto others, and Aasha said she felt really angry that, “the discourse around anti-medication’s still out there… it’s so unhelpful… I’m living proof that it can actually save lives”. Aasha went on to describe how it made her feel when others talked about getting through their problems medication free: “I just felt really ashamed that I couldn’t do that myself but I think, the medication coming in has taken the heat off a lot of the feelings and above that I can use my skills.”

Not all of the young people who were prescribed or offered medication said it was part of their long term recovery. Sam described it as a “stop gap” measure that helped “deal with a situation”. Faye described only taking medication occasionally when she felt like it was her choice, and felt that diagnoses tended to inevitably lead to being prescribed medication: “‘Oh you need to start taking Fluoxetine and Olanzapine’ and it’s like ‘fuck off, no. I don’t want to. I’ve come this far without it’”. Faye described only using medication when it felt like a choice and positioned her focusing on therapy over medication as a “harder, longer kind of road” but one that would lead to a deeper type of “healing”.

As with the other interventions described in this section, young people described a diversity of opinions on, and experiences with, medication. Many young people positioned medication as an important aspect of their recovery, although they also described struggling with side effects and seeing the benefit of using medication in conjunction with other interventions. There were also young people who resisted medication being “pushed” onto
them, and successfully exerted agency in this part of their treatment. This diversity of experience fits with existing New Zealand literature that has explored adult experiences of long-term use of psychiatric medication (Cartwright, Gibson, Read, Cowan, & Dehar, 2016).

**Different therapies for different times.**

Most of the young people interviewed spoke about experiences of psychological therapy. Within this, a diversity of experience was described, with young people appearing to value different things at different stages of their recovery.

Sam and Jared emphasised the importance of having a space to talk things through and feel listened to. However several young people described practical help as being far more useful than trying to gain insight into their difficulties, especially when they were, “in the thick of it”, and actively trying to cope with being unwell or with stressful life circumstances.

Faye and Aasha both talked about notably positive experiences when a therapist supported them to gain independence. This was described as being beneficial for two reasons—on one hand it helped young people feel believed, validated and understood, while also providing “solutions” to the problems they were facing at the time. However, it is important to note that the positive practical help that was described seemed to work to promote their agency and autonomy, rather than directive and involve telling them what to do.

Other young people described how a more active therapeutic approach helped them feel hopeful about the possibility of change. Charlotte’s description of the difference between the two psychologists she saw at age 14 exemplifies this:

The second psychologist I started seeing, wonderful woman—she’s really cool—we started doing CBT and I felt like we were actually doing something and someone was actually trying to make a difference. With this first woman it just felt like she asked me how I was and then sent me away to come back next time. And who knows, I mean maybe she was into narrative approaches or something, I don’t know, but that was my
perception at the time—that just nothing was happening and nothing was going to change that way.

Many of the young people interviewed cited “learning strategies” as an important part of their recovery process. Similarly, Jayita described how personal trainer Lucy’s practical, “fix it” approach was more helpful than conventional talk therapy. She described there being a place for counselling in her life, but that a practical, problem solving approach needed to come first.

Jayita’s description of needing to, “get on the road” before “talking”, was echoed in other young people’s stories. While Faye found practical help very useful when younger, she described that later on, trauma therapy really helped her to understand her experience which was an important part of her healing process. Charlotte described that while CBT was a good fit for her when she was 14, she needed something different when she was further along her recovery journey:

I went to community mental health at that point, so into adult services but for whatever reason I just didn’t … the relationship with me and the psychologist there just didn’t gel. I think too that we were going back to, sort of went back to the beginning of CBT. I’d been doing CBT for a gazillion years and it only took me so far. It kept me alive but it never made me happy.

Existing youth literature suggests that while some young people emphasise the importance of talking things through and being listened to, over and above skills and problem solving (Lynass et al., 2012), other studies have found that young people highly value concrete advice and problem solving (Buston, 2002; Day et al., 2006; Garland & Besinger, 1996; Lavis & Hewson, 2011; McCann & Lubman, 2012; Persson et al., 2017). This suggests diversity in what people value from psychological therapy, both when comparing different individuals, and for the same individual at different stages of their life (Gibson & Cartwright,
2014). This once again demonstrates the emphasis young people put on helping professionals “getting” them, and being attuned to their specific needs in order to help foster an environment conducive to recovery.

**Sometimes it’s better with peers.**

Several young people spoke about positive experiences with peer services, and also mentioned informal interactions with fellow service users as particularly helpful aspects of their service use. Kalena described feeling like some older services users took her, “under their wing” and looked out for her because, “they knew I was young, they knew I was new”. She described their support as being characterised by “a mutual understanding”. Vijay recalled how one man he met in hospital gave him advice to, “live life like it’s one day at a time”. He described this as continuing to heavily influence his approach to life and identified that conversation as the biggest things that helped his recovery.

Kalena and Isieli both described not being able to heal until they had contact with peer support services. Kalena experienced peer services as providing genuine care and warmth which made her feel “100% accepted”, and Isieli described finally being, “able to find recovery” when spending time in a peer led respite. For him, connecting with people who had gone through similar experiences provided a type of support he hadn’t experienced before, and also helped him to learn new ways to cope with negative thoughts. Chris also talked about his peer support worker as being one the most helpful aspects of the support he received from mental health services.

For many young people, interactions with other mental health service users or peer lead interventions were described as supportive of their recovery process. This was largely linked to intangible factors such as feeling accepted and supported, but also linked to sharing of coping skills. Explicitly talking about the benefits of peer support is perhaps unsurprising
considering that many of these young people now work in the role themselves. It also fits with existing literature that suggests young people highly value mutuality and less formal methods of contact (G. Leavey et al., 2011; Gibson et al., 2016; Persson et al., 2017).

**Personal Agency and Engagement**

When considering commonalities in themes across participant’s accounts, it was once again striking that young people placed a great deal of responsibility on themselves to effectively use services to support their recovery. However at the same time, they also described how being young negatively impacted their ability to effectively engage with services, and feeling as though they lacked agency and control over their own treatment. While a few young people tried to explicitly address this, more often they described using more covert tactics to cope with this perceived lack of control.

**You’ve got to want it and be ready.**

Young people described how having contact with support services wasn’t enough, and that one had to “want”, be “willing” or get “serious” about the active and difficult task of getting better. Not being ready was described in terms of not genuinely engaging or utilising available services. Isieli described how initially his engagement with mental health services was very superficial:

I was still trying to figure out myself at the time you know with my voices and with everything that was happening at the time. All I could think of was, ‘I just want to do drugs’. Like I just didn’t really see the point. There were times when I, like I say to myself ‘why did I look for the help? I should have just stayed like that’ you know?
Isieli described that during this time he was provided with useful information from services and encouraged to do things that might support his recovery; however, he didn’t put these things into action.

Young people described different factors as contributing to “being ready”. Charlotte positioned a process of internal realisation as contributing to a change in the way she engaged with counselling. Prior to being ready to address her “food issues” she would deflect therapists’ questions about her low weight saying, “it’s not a problem, it’s not a problem”. She contrasted this to actively seeking out a therapist who specialised in eating disorders, after she realised that her low mood and issues with food were intricately linked. She described this as representing “a real key turning point” for her and marking the moment when she, “got serious about treatment”. Charlotte went on to position the influence of this therapist as a small part of an ongoing personal journey: “Yeah she got me quite a long way and then you do the rest yourself don’t you. You just keep going and make it happen”. Lucy and Jared shared a similar sentiment, describing how being willing to get better and taking responsibility for one’s own recovery was crucial. Jared reflected on how he changed from being “avoidant”, lying to his psychologist and saying whatever he needed, “to get out of the situation”, to having a “willingness to learn” and start using his support networks. Similarly, Lucy said, “no one else is going to do it for me, I have to do it for myself.

Overall, young people once again described that effectively utilising services to support their recovery required active engagement and a level of personal responsibility. This strongly reflects adult recovery literature (Leamy et al., 2011) and also the small amount of existing literature that explores youth perspectives on recovery and service use (Gibson & Carwright, 2013; Rayner et al., 2018; Romano et al., 2010).
Being young makes it harder.

Despite the responsibility young people placed on themselves to be ready and willing to engage, “being young” was associated with an absence of power and choice that was positioned as making it hard to engage with support services.

Several young people described feeling as though being young impacted their ability to effectively get the help they needed, a concern that was particularly pertinent to the young people who described not having the support of their families. Both Faye and Sam talked about the difficulty of engaging with their GP in order to get more specialised mental health support. Faye explained:

Your parents choose which doctor you go to… I think my mum was trying to be protective and went to a doctor that she feels she could have asked questions about me and wanted to come into my doctor’s visits. So like, I even felt like I couldn’t trust my doctor that much because she would have just told my mum stuff.

Sam on the other hand, focused on the practical implications of having to see the family GP, who was situated on the other side of town, meaning they either had to go with their mother ("awful") or catch a bus and remember where to get off. Aasha described facing similar practical issues in regards to independently making her way to therapy appointments at the local CAMHS, explaining that:

I never missed an appointment, which was hard because I didn’t have my parents taking me so it was like two bus rides and quite a lengthy walk. And I wasn’t eating well at the time as well, so I was feeling really quite exhausted. So, I think the physical kind of fatigue, as well as the emotional fatigue was quite… like it didn’t help me to engage.

Here, Aasha seems to position the practical implications of her age related lack of independence as augmenting the impact of her distress, and therefore making it harder to
engage with services. Aasha also described her parent’s attitudes towards “mental health issues” as a barrier to her engagement, explaining that they, “didn’t allow” her to take medication at one stage. Interestingly, young people who described feeling well supported by their families put much less emphasis on the idea that being young made it difficult to engage with services.

In New Zealand, it is considered good practice to involve a young person’s family in their treatment (Appleby & Phillips, 2013). However, as Aasha’s account exemplifies, this has the potential to be severely limiting for young people whose parents are not supportive of this and the prospect of family being informed about their difficulties appeared to put some young people off seeking help. Overall, despite the responsibility young people placed on themselves to “want to get better” and “choose” to actively engage, they also described serious structural and social limitations on their ability to engage with professionals and work towards recovery.

**I couldn’t find my voice.**

The young people in this study described a pattern of not challenging treatment they didn’t find helpful and not explicitly asking for things to change. For some young people, this was attributed to a lack of knowledge—about the “system”, medication or their rights as a service user. Kalena described this in relation to her “really horrible experience” of being put on anti-psychotic medication for the first time, when side effects “numbed” her and made her feel like an emotionless “zombie”. She positioned herself as naïve about medication and “new to the system” saying:

[I] didn’t realise that I had any right to ask for a different medication or challenge whether I was on too much because I was new. I didn’t have any information so I just went with it, didn’t know I had to, I didn’t know I didn’t have to.
Sam recalled never saying anything to the family therapist who let their mother Jenny “walk all over” Sam during sessions. On reflection, Sam felt the therapist should have done more to address the imbalance in the room:

He took the curled up, sobbing 16 year old at their word when they said they had nothing to say. You know? He said “do you have anything to say about this?” and I said “no” and he said “alright then”. Maybe something else is going on here!

Sam seems to imply that therapists working with young people should know it is difficult for them to speak their mind, especially in the context of difficult family dynamics, which was the reason the family were in therapy. When reflecting on experiences with services as a whole, Sam said, “if anything, I think my main issue was that I felt like I didn’t feel like I could necessarily say when I felt like things weren’t working”.

Aasha described feeling that although her sense of agency had increased over time, she had not felt comfortable enough to ask for a change of key worker during her most recent experience with services because it was too intimidating. She described dealing with the situation by avoiding her key worker, “I don’t speak to her really, mostly ‘cause I find her really intimidating”. She suggested that a combination of age and cultural factors likely contributed to her tendency to keep quiet about what she needed for herself. Aasha did describe one occasion when she had felt able to explicitly state her needs when she was offered six sessions of therapy and said, “No, six sessions isn’t going to cut it”. This led to her being referred to community MHS for more intensive care.

Overall, young people described it being difficult to overtly express their wishes or speak up when treatment was not working for the. This is consistent with Gibson and Cartwright’s (2013) finding that in the context of counselling, young people positioned themselves as highly active agents, whilst also finding it difficult to assert their wishes and
opinions. Aasha’s success when explicitly asking for what she needed was the exception, with young people far more often describing failed attempts to exert agency or utilising covert strategies to deal with a perceived control in their treatment.

**Opting out and covert resistance.**

Many young people described leaving a service or “opting out” as the primary means of dealing with treatment they didn’t like. This approach manifested in a range of ways, from “just not going back” in the context of one-off interactions, to dropping out of weekly therapy.

Sam and Faye described not returning to see a therapist after a bad experience, despite the problems continuing. Similarly, Aasha also left a service due to a bad experience with a clinician, despite feeling suicidal and desperate for help:

My psychologist at the time was pregnant and she kept cancelling my appointments. And you can understand, I was really in the depths of like feeling really depressed and suicidal and this was my last kind of ditch attempt at getting better and to continuously have it um cancelled… was really difficult for me. So, I got really frustrated, as I did, and left and struggled a lot for the next year or so.

Aasha described this experience as having a big impact on her, and in hindsight wished she had been able to change therapists and see someone who was more reliable and consistent. Reflecting on the experience she said:

I didn’t really seem like I was engaging, and I get that because I wasn’t really, but I told them ‘You know, the only reason I’m here is because I’m so desperate. Like I know I’m going to die so if I don’t do something here, then that’s it for me’ but there was not support for that. There was no like change or someone else didn’t contact me or you know, any of that.
Aasha’s experience highlights the serious potential consequences of young people voting with their feet and dropping out of treatment they are not happy with, even if still feeling “desperate” for support.

Jayita on the other hand described putting up with a psychiatrist she didn’t like while utilising aspects of the service that she felt were beneficial, until she felt ready to leave:

I just didn’t relate to that psychiatrist but she got me into an anxiety management course which I almost finished, I did most of it. It was pretty good. It was pretty good at the time ‘cause I think it was a lot around anxiety but then after that I just… I stopped going. I just decided I didn’t need this anymore. Like continued with Citalopram but just didn’t go to community mental health cause, I didn’t like my psychiatrist and I didn’t want to do the anxiety stuff anymore and I was feeling a lot better after that as well.

In this sense, despite not requesting a change in clinician, Jayita did exert agency over her treatment by picking and choosing the aspects of treatment she liked, and leaving once she felt she got what she needed from the service.

In lieu of explicitly asking for what they wanted, young people described dealing with treatment they didn’t like by using covert ways to exert control. A number of participants spoke about lying to clinicians, including Isieli who said, “they put me on medication and some of the medication had side effects I didn’t like, so I used to just lie to them… they will take me off medication and probably put me on another one”. While not actively lying, Lucy described exerting agency by stopping her Ritalin without telling her parents and doctors. She positioned this decision as a success—“the best thing I ever did”. Jared also described stretching the truth to successfully avoided having to take anti-depressants:
My GP who prescribed some medications, but my mum has bipolar and I basically said to her that I don’t want to do this and then she went to her…I’m not sure if it was her GP or her… they said it was a bad idea and then I sort of used that information to say ‘no I don’t want anything’ but like I didn’t want to fight so I basically said “my mum doesn’t want me doing this”… I remember fighting with my dad a bit about that but I never got onto any medication.

Jared described similar success with his approach to dealing with “embarrassing” therapy homework–lying about doing it until his therapist moved away from assigning it. Aasha also reported finding therapy homework “uncomfortable” when she was younger, so she just did not do it.

Overall, rather than passive recipients of care, young people described finding creative ways to exert some control in their interactions with professionals. While some young people described being able to use these strategies effectively to support their recovery, for others the gains were more short term. These findings fit closely with those in a recent New Zealand study examining young people’s agency in counselling (Gibson & Cartwright, 2013).

Helping Others: Working on the Other Side

The young people who took part in this research represent a specific group of people who have both used services and then gone on to influence them in some way, either through directly working with people or offering a “consumer” perspective on service provision. The two themes in this final section focus explicitly on this.
Working helped my recovery.

Many young people talked subsequent work in mental health as an important part of their recovery process. Sarah described how when she started working she was still really struggling, saying, “I was a fricking mess when I started working here”. She described how her work had helped her “gain so much confidence and skills…this place has helped me grow so much as a human being”. Kalena also described training and working in peer support as helping her to “grow”, as well helping her to rebuild her self-esteem and start loving herself again. Sarah and Kalena’s emotive language typified the way young people tended to speak about their work and work place. Sarah explained in more detail why she felt it had been so helpful, saying, “it is like having a role model everywhere. Like mental illness working for people. It’s role modelled in every person in this building and I just gives me heaps of hope.” Kalena described how her training and work environment helped her to accept her diagnosis more quickly:

It wasn’t long after I got diagnosed that I started working here and did my PET training so I suppose for me the level of acceptance around it for me was fast-tracked because I was in an environment where it was okay and actually you needed to have that and that was seen like a benefit instead of a deficit.

Aasha described how working on “the other side of the system” had been part of her recovery, making particular mention of attending a meeting (in her capacity as a consumer advisor) that was held at a service she used when she was younger.

Young people also described there being practical benefits to working in a peer environment. Vijay described feeling as though working in peer support had improved the level of care he received from clinicians, “I would say when you’re unwell and you’re not a peer support, psychiatrists don’t really care about you. If you’re a peer support and you’re
unwell, they do give a care about you.” There was also a sense conveyed by many of the participant’s, that their employers were particularly understanding and encouraging of their need to maintain their wellbeing, and offered emotional support, supervision and flexible working hours to support this.

However working in mental health as a young person with “lived experience” wasn’t described as entirely unproblematic. Sarah described finding it initially challenging to work with clients who had similar issues to her, while Faye spoke about trying to balance her consumer role and her background of clinical training. She described sometimes feeling pressure from others in the peer field to “be louder and prouder” about her lived experience, which didn’t sit comfortably with her.

Overall, young people described their work in mental health as helping them to grow in confidence, develop new skills and feel hopeful about their futures. Many, especially those working for NGOs, described feeling as though their employees supported them to maintain their own wellbeing. Existing research supports the idea that working in a peer or consumer role may help the recovery of the person themselves (Ahmed et al., 2015; Ahmed & Buckley 2014; Salzer et al., 2013).

**Changing the system.**

Many of the young people I spoke to told me that they had volunteered to be involved in the research in the hope that their story could in some way contribute to the improvement of mental health services. Overall, young people described the mental health system as not serving them particularly well but had become involved in peer support to improve the system for others. Most felt that that mental health services were improving over time but several described negative experiences with clinicians as representing a “hangover” from an institutional approach to mental health service provision.
Many of the participants also had suggestions for how things could be better. Jared offered suggestions about how the discharge process he experienced could have been improved:

Follow-up sessions and aftercare I think would have been really good because, honestly, I’m not sure if when I was released I was fine. Like Napier was a really hard time for me and then I had to deal with a lot of things there… I just sort of fell out of the mental health system.

Young people also spoke about the need for increased awareness of mental health issues and suggested that mental health education be incorporated into school curriculum. Chris said ”I think there needs to be education about things in the same way as a kid in school [pause] you know, like you learn about sexual health and stuff”. Jared echoed these sentiments and also suggested that providing extra support for young people during stressful times, such as starting a new school, could be helpful. Vijay described the importance of increased accessibility–preferably 24-hour services, even if it was just an online service, while Faye thought that recovery could be better supported if people had more flexibility in and choice over treatment:

I totally wish that say for every person who had un-wellness or these kinds of struggles or whatever, if they could choose how they spend their health dollars on themselves, whether it be paying for swimming during the summer and paying for yoga during winter, yeah I would do that in a heartbeat. Whether it’s paying for a sensitive claim to see a therapist or whether it’s being able to support your employer to give you flexible hours and stuff like that.

These young people’s call for increased flexibility in service provision aligns with existing research that suggests accessing services is difficult (Persson et al., 2017;
Summerhurst et al., 2017) and that young people prefer services that can fit more easily into their lifestyle (Gibson et al., 2016). A desire for increased agency in regards to the type of treatment to engage in, reflects both general recovery principles (Leamy et al., 2011) and specific youth concerns (Binder et al., 2011).

Summary

In summary, young people described professional support as difficult to access and engage with for a variety of reasons. As such, navigating services was described as a challenge to overcome, rather than something that facilitated and supported personal recovery. Despite negative experiences with the system as a whole, most young people described positive and helpful relationships with specific professionals. They strongly emphasised the importance of the relational aspects of their care and described positive relationships as supportive of service engagement and recovery, with negative ones hindering both of these processes. They also described the impact—both positive and negative—of specific interventions they experienced during their contact with services and professionals. Overall, young people positioned themselves as active agents in their recovery and described needing to be ready to engage for professional help to be beneficial. However they also described feeling limited in how much control they could actually exert over their treatment. While they described a number of covert ways of getting around this, these strategies only appeared to work well for some young people long term. For many young people, working in mental health appeared to play a role in their ongoing personal recovery journey. Some of them appeared to be motivated to change a system they described as not serving themselves or other young people very well, and many had specific suggestions about how youth mental health services provision could be improved in this country.
Chapter Six: Discussion and Conclusions

The purpose of this research was to gain insight into how young people in New Zealand make sense of their experiences of having a serious mental health problem and their recovery. I also aimed to explore how young people understand the role of professional support in the recovery process. This research was intended to contribute to the currently scarce literature on youth perspectives on recovery, especially in a New Zealand context. In this chapter I will identify the key findings from both the narrative and thematic analysis and discuss these in the context of existing literature. Practical implications of the overall research findings will also be discussed, followed an examination of the strengths and limitations of this study and finally, suggestions for future research.

Narrative Analysis: Stories of Recovery

A narrative analysis identified that young people described the process of recovering from mental distress as an extremely personal journey. One of the most significant findings of this analysis was that young people storied their journey of recovery in quite different ways. This is largely consistent with the adult literature, with the concept of recovery being largely developed out of unique, heterogeneous accounts of personal recovery (Brown, 2008; Davidson et al., 2005; Deegan, 2002; Jacobson, 2001; Lapsley et al., 2002; Rhodes & De Jager, 2014; Thornhill et al., 2004). In the present study, the variation in how young people storied their personal experiences appeared strongly associated with the different ways they conceptualised “the problem” or cause of their mental distress. Within these unique, personal narratives, five different “types” of recovery stories were identified.

The differences in each narrative type hinged around several features of the story, and the causal explanations that guided each narrative type were identified as significant for
multiple reasons. The conceptualisation of the problem not only elucidated young people’s personal perspectives on the causes of mental distress, but also foregrounded the relative dominance of certain models of mental health, and the influence of cultural “stock stories” or ideas. For example, the “sensitive me” narratives strongly reflected bio-psycho-social etiological explanations, describing genetic predispositions to mental health difficulties, and psycho-social triggers (Read, et al., 2008; Read & Sanders, 2010). These stories also reflected cultural counter-narratives around sensitivity being a virtue (Aron, 1997; Lionetti et al., 2018. In contrast, the “surviving the chaos” narratives appeared much more strongly influenced by trauma perspectives on mental health difficulties (Perry, 2009; Schwarz & Perry, 1994). These stories, along with the “not me, the situation” narratives did not reflect cultural ideas about “silver linings” to negative life events that were identified in narrative types that located the cause of distress as within themselves.

Secondly, and very importantly, the conceptualisation of the problem appeared to guide the specific recovery “tasks” young people described as playing a role in the process of getting better. This key finding closely mirrors Jacobson's (2001) analysis of 30 adult recovery narratives, in which she identified that the protagonist’s explanatory model of what had happened, why it happened and what they needed to do to “recover”, was the narrative pivot around which recovery stories were based. Similar to the Jacobson study, it was identified in this study that naming and framing the problem appeared to guide the process of recovering from it. For example, young people who described their mental health difficulties as primarily caused by an innate sensitivity or pre-disposition, described embarking on an active and ongoing process of developing self-awareness and self-management, which helped them to minimise the likelihood of their vulnerability being triggered in the future. In comparison, young people who described the primary cause of their difficulties as being a stressful environment and age-related lack of agency, described the normative task of
“growing up” and an associated increase in independence and autonomy, as being of primary importance to things getting better for them.

Thirdly, the way the problem was identified also appeared to link to how the young person conceptualised their sense of self. While the protagonists in the “sensitive self” narratives positioned experiences of mental distress as a fundamental part of the self, those in the “bad choices” narratives described their drug and alcohol use, and subsequent experiences of mental distress, as causing them to temporarily “lose” their sense of self. So while in the former narratives young people described a process of accepting themselves, in the latter they described a process of reconnecting with the self they had temporarily lost touch with. While the young women in the “surviving the chaos” narratives described a dramatic transition in identity, protagonists in the “not me, the situation” stories described that increased independence and autonomy associated with growing up, meant they were able to shape their environment to better suit their personality. Identity was perhaps positioned as most central to recovery in the “product of the system” story, with the protagonist describing a lifelong drive to find out who she really was, and linking her interactions with the mental health system as significantly hindering her ability to do this.

Overall the narrative analysis suggests that there may be considerable variation in the way that young people experience recovery. Whilst existing youth recovery research acknowledges that recovery is a unique, personal journey, studies have primarily focused on identifying common themes and similarities across young people’s recovery experiences (Barnett & Lapsley, 2006; Bergmans et al., 2009; E.J. Leavey, 2009; Rayner et al., 2018; Romano et al., 2010; Simonds et al., 2014; Woodgate, 2006). While the identification of common themes and conceptual models and process offers an important contribution to the field, the variation identified in this study emphasises the importance of remembering that general models of recovery may apply or manifest quite differently for individual young
people. For example, Romano and colleagues (2010) finding that young people maintained an enduring sense of self throughout their experience, applied to some of the participants in this study but not all.

Due to its focus on the particularity and specificity of accounts as a whole, the narrative analytic method utilised was particularly helpful in illuminating the nuances of youth recovery. Whilst narrative analysis has been commonly used in adult recovery literature (Kirkpatrick, 2008; Rhodes & De Jager, 2014), this study makes a unique contribution to the current body of youth recovery research by utilising a narrative analysis, rather than thematic or grounded theory analysis underpinned by a narrative approach.

However, it was also possible to identify broad themes associated with the adult recovery literature across the different types of recovery narratives (Leamy et al., 2011). Throughout all five narrative types, identity was positioned as central to young people’s experiences, which is consistent with suggestions that establishing identity is of significant concern for young people in contemporary western societies (Baumeister & Muraven, 1996; Erikson, 1963, 1968; Giddens, 1991a). For many young people, having a mental health problem from such an early age was described as having considerable implications for their identity. Many described struggling to make sense of how their difficulties arose, what a diagnosis meant for them, and how they could turn it into something that helped them live their lives. Young people described recovery as a process of gaining knowledge about the self and then accepting, reconnecting with or transforming their sense of self in relation to their experiences of mental health difficulties. While these ideas are commonly discussed in both youth and adult recovery literature (Leamy et al., 2011; Rayner et al., 2018; Romano et al., 2010; Simonds et al., 2014; Woodgate, 2006) they also reflect wider cultural narratives about working through problems located within the individual, suggested to have been perpetuated by the “psy” professions in late-modern Western societies (Rimke, 2000; Rose, 1990, 1996).
Young people who identified with ethnic minority groups also talked about challenges specifically linked to cultural identity, consistent with suggestions that contemporary patterns of migration and increasingly multi-cultural environments may add complexity to young people’s identity formation (Butcher & Thomas, 2003; Manuela & Sibley, 2014; Paradies, 2016). That identity was a significant feature of young people’s recovery narratives was consistent with existing youth literature (Rayner et al., 2018; Romano et al., 2010; Simonds et al., 2014; Woodgate, 2006). While identity has been recognised as important in the adult recovery literature (Leamy et al., 2011), the present study supports suggestions that experiences of mental health difficulties may pose significant and unique challenges to a developing sense of self that young people may need to overcome in their recovery (Rayner et al., 2018; Ward, 2014).

Another common feature across narrative types was the emphasis on personal agency, empowerment and individual responsibility. This has been identified as a core aspect of both adult and youth recovery (Barnett & Lapsley, 2006; Leamy et al., 2011; Rayner et al., 2018). Young people positioned themselves as active agents who were responsible for driving the process of recovery. The emphasis on personal responsibility was present to some extent in all of the young people’s stories, perhaps reflecting what has been referred to as a defining characteristic of contemporary western society—the individualisation of problems (Bauman, 2000; Beck & Beck-Gernsheim, 2002; Giddens, 1991; Rimke, 2000; Rose, 1990:1996; Schwartz, 2004). However, the exact nature of this responsibility differed between the different narrative types and appeared related to the original conception of the problem. For example, it was emphasised more heavily in the stories of young people who located the cause of their distress as being due to an innate predisposition or their own choices, compared to the stories of those who positioned distress as a result of external circumstances.
While the young people in this study described an admirable sense of their own agency, this was also associated with a considerable sense of burden, leaving open the possibility that young people may take on too much responsibility (and blame) for their own well-being, in an environment that puts significant limitations on their ability to exert agency (France, 2007; France & Threadgold, 2016). In the “not me, the situation” narrative type in particular, these age related limitations on agency were positioned as contributing to the development of psychological distress. The findings of this study are consistent with existing research that has highlighted that young people highly value agency and autonomy (Gibson et al., 2016; Persson et al., 2017) but may also face considerable challenges in successfully exerting agency over the treatment that is supposed to support their recovery (Gibson & Cartwright, 2013; Harper et al., 2014; MHCC, 2014). Current youth recovery literature has also highlighted that young people are much more dependent on their systems of care than adults, which may also have significant impact on the amount of responsibility they can take for their own recovery (Rayner et al., 2018; Romano et al., 2010; Simonds et al., 2014, Ward, 2014). This is a perhaps a particularly important difference when considering youth and adult recovery experiences.

Connection was another recovery concept that was identified as salient across narrative types. Many young people described feeling alone and isolated while unwell—if not before—with some positioning disconnection from family and friends as contributing to, or at least amplifying, mental health issues. Some young people, especially those in the “bad choices” narrative type described that stigma related to their mental health difficulties led to a loss of connection with friends and family. This finding fits with international research that indicates young people with mental health issues often experience stigma in their family and peer environment (Moses, 2010b; Romano et al., 2010). There was also a practical component to this loss of connection, with young people who described a tenuous
relationship with their family appearing to experience more difficulty accessing and navigating the services designed to help them with recovery. Conversely, all of the young people in this study described connection as both helping the recovery process and/or being a consequence of progressing in their recovery.

These findings fit with both adult and youth recovery literature that describe recovery as a process of moving from disconnection and isolation towards feeling connected and supported (Barnett & Lapsely, 2006; Leamy et al., 2011; Rayner et al., 2018). Relationships and connection with others have also been identified as key aspects of wellbeing by young people with mental health diagnoses (Honey et al., 2015; Lal et al., 2013; Lal et al., 2014).

The findings of this study also suggest that broken connections may have more significant practical implications for young people’s recovery process, in part due to the particular limitations young people face in exerting personal agency as discussed above.

Another common theme in adult and youth recovery literature, hope and optimism about the future (Barnett & Lapsley, 2006; Leamy et al., 2011; Rayner et al., 2018), was identified to vary between the narrative types. All of the young people described, most often implicitly, believing in the possibility of recovery. The fact that the study explicitly sought to attract young people who considered themselves “some way along the recovery process” likely contributed to this. In different ways, the “sensitive self”, “bad choices” and “not me the situation” stories were relatively hopeful, with young people describing that they felt more equipped to deal with “the problem” going forward. The narrative type that offered perhaps the least optimistic outlook was the “product of the system” story, which lacked a coherent narrative regarding the cause of mental health difficulties. This finding perhaps adds weight to suggestions that making sense of negative life events is associated with more positive adjustment (McAdams, 2006; McAdams et al., 2001; McAdams & McLean, 2013).

These findings, taken in conjunction with the centrality of the causal explanation young
people developed to account for the development of their difficulties, suggests that making meaning is as relevant to youth recovery as it is to adult recovery (Leamy et al., 2011).

**Thematic Analysis: The Role of Professional Support in Recovery**

A thematic analysis was conducted to gain further insight into how young people understand the role of professional support in their recovery. Although critical of services overall, young people seemed to be able to appropriate useful aspects of interventions they were offered, into their own recovery journey. While they emphasised the relational aspects of care, they also spoke about the positive impact of other interventions including medication, therapy, and formal and informal peer supports. Once again, personal agency was described as vital to successful engagement with services, yet also problematic and difficult to exert. The analysis, which aimed to identify and examine patterns of meaning across the participants’ stories, was divided into five sections: Struggling with Services; The Human Relationship; The Impact of Interventions; Personal Agency and Engagement, and; Helping Others: Working on the Other Side.

Overall, services were described as fragmented and hard to reach, with young people having to work hard to create their own recovery. Some described this as negatively impacting their view of health services and also as representing a challenge to overcome in recovery, rather than facilitating and supporting the process. These findings are generally consistent with existing youth perspectives literature that suggests accessibility is a salient issue for young people with mental health issues (Buston, 2002; Houle et al., 2013; McCann & Lubman, 2012; Lavis & Hewson, 2011; Persson, et al., 2017; Summerhurst et al., 2017). A number of young people described feeling like they had to be in extreme crisis to get help, even once engaged with mental health services. This finding adds weight to concerns
expressed in New Zealand about young people having to reach a crisis before accessing services (Barnett & Lapsley, 2006; Elliott, 2017; Mental Health Commission, 2006, 2012).

The tendency for young people to come into contact with services in the context of a crisis may in part be accounted for by another finding of this research. Some participants described feeling conflicted about talking to their GP, in part due to concerns about their GP being too closely aligned with their parents or too difficult to access without parental support. This is consistent with views of young people in Australia and the United Kingdom who expressed reservations about seeing a GP for mental health issues (Biddle et al., 2006; G. Leavey et al., 2011). Considering the increasing role of primary care in the provision of mental health services in New Zealand, this finding is significant. However, there were also some young people who had positive experiences with GPs which lead them to access services before crisis point.

Young people also talked more specifically about feeling that the care they received was not appropriate to their age. Negative interactions with services were described in terms of being treated like “a child” or conversely, being left to their “own devices” and not offered enough support. Both types of age inappropriate experiences were described as leading to negative emotional experiences and as hindering, rather than helping the process of personal recovery. The relevance of age to service experience has been highlighted previously (Buston, 2002; Harper et al., 2014), and supports the overall proposition of this study, that while youth may face many of the same challenges as adults in relation to recovery, being “young” does lead to unique experiences and challenges that need to be considered if services are to provide genuine recovery-oriented care.

Young people also described feeling confused and uncomfortable with aspects of their interactions with mental health professionals and other services. Their comments highlight how some of the common processes and practices implemented by services in New
Zealand may impede the ability of young people to use services in a way that facilitates recovery. Congruent with existing research, young people described that having to talk to multiple clinicians and teams in the early stages of treatment was exposing and intimidating (Buston, 2002; Garland & Besinger 1996). Some also expressed particular concern about having to share personal information in front of their parents. Concerns related to parents being involved in sessions has been well documented in the existing literature (Day et al., 2006; Gibson et al., 2016; Persson et al., 2017; Strickland-Clark et al., 2017). These concerns appeared particularly salient for young people who felt that their parents or family situation were contributing to their difficulties. Many of these aversive experiences were described as occurring during initial stages of treatment, which is significant considering many researchers have found that young people require time and space to develop a relationship with clinicians, before opening up about personal matters (Hartzell et al., 2009; Lavis & Hewson, 2011; Lindgren et al., 2014; Persson et al., 2017).

Another important issue raised was the lack of integration between different services and agencies, especially at the interface between mental health and addiction services. Half of the young people in this study described experiencing significant substance abuse issues at some point along their journey, a ratio in line with available statistics on co-morbidity in New Zealand (Todd, 2010). The need for better coordination and integration at the interface of mental health and addiction services for young people has been highlighted by this study.

It was interesting to note that some young people who spoke at length about having negative experiences with the system, also made comments such as “overall I had really fantastic treatment” and “I have been so lucky to have received great treatment”. This apparent contradiction could be explained in a number of ways. The fact that the participants in this study were working in mental health may in part account for this discrepancy. While most were working as peers or consumers—rather than clinicians—there still may have been
something to be gained by believing that the system they work in serves young people well. The positive relationships with individual clinicians that many young people described, may have also coloured young people’s overall sense of their experience. From a narrative perspective, this more positive overall sense of service experience may play an adaptive function for these young people, with there being some evidence to suggest that accounts of negative experiences characterised by positive resolutions, are associated with higher levels of subjective wellbeing (Lilgendahl & McAdams, 2011; Pals, 2006; Tavernier & Willoughby, 2012).

Themes related to “the human relationship” highlighted that despite many systemic issues, young people remembered and valued relationships with specific professionals. Young people described the importance of feeling listened to, understood and believed. They also emphasised the importance of mutuality and equality in their relationships with professionals, which is perhaps unsurprising considering the importance they placed on personal agency. These are messages that have been consistently identified in youth perspectives literature (Biering, 2010; Buston, 2002; Garland & Besinger, 1996; Gibson et al., 2016; Lavis & Hewson, 2011; Lingreen et al., 2014; Persson et al., 2017). The emphasis on “genuine connection” and being able to “relate” to professionals also supports the case for diversity in regards to mental health and other health professionals in New Zealand (Durie, 2011; Statistics New Zealand and Ministry of Pacific Island Affairs, 2011).

Many young people in this study described personal disclosure and reciprocal relationships as being particularly helpful. This may be unsurprising considering so many of them described finding peer interactions and interventions helpful, as personal disclosure from clinicians could be considered to bridge the gap between “expert” clinical knowledge and “lived” expertise. Anthony (1993) who has made a significant contribution to adult recovery literature, once highlighted that:
The recovery experience is not an experience that is foreign to services personnel. Recovery transcends illness and the disability field itself. Recovery is a truly unifying human experience. Because all people (helpers included) experience the catastrophes of life (death of a loved one, divorce, threat of severe physical illness and disability), the challenge of recovery must be faced. (p. 527)

The sentiment of Anthony, and the young people in this study, supports a growing body of research that suggests self-disclosure and reciprocal relationship can be associated with positive therapeutic outcomes, (Farber, Berano, & Capobianco, 2004; Henretty & Levitt, 2010; Knight, Gibson, & Cartwright, in press; Levitt et al., 2016). Overall, strong personal connection or “therapeutic alliance” was often described as making the difference between engaging in services or not, particularly in the case of young people who felt ambivalent about their treatment. Conversely, poor therapeutic alliance was described as contributing to early termination of treatment, in line with de Haan and colleagues (2013) meta-analysis that suggested poor therapeutic alliance is a robust predictor of treatment drop out in child and adolescent mental health services.

Despite difficulties with services as a whole, young people described certain interventions as playing a significant role in their recovery. The intervention that was described in the least positive light was being given a diagnosis. As described above, for many young people, this had significant implications for their sense of self, mostly described as negative, particularly for those young people who were given multiple diagnoses or labelled as having a personality disorder. Some young people also described feeling as though diagnoses were particularly “dangerous” if received at a younger age. However in New Zealand, to be eligible for public mental health services, one must be considered to be in the most severe 3% of mental health psychological distress/difficulties (Appleby & Phillips, 2013; Mental Health Commission, 2011), which in the current system ultimately
means being considered to meet criteria for a psychiatric diagnosis. Therefore in the current environment, these young people may have not been able to access interventions that they did describe as being helpful, without a diagnostic label.

One of the interventions many young people described as playing a role in their recovery was medication, despite it often being described as a long, arduous process to find the “right” one. For many young people, it was almost taken for granted that the ongoing use of medication was a crucial part of their recovery, despite describing significant side effects. It was interesting to note that this sentiment cut across narrative types and was expressed by some young people who overall provided a very non-biomedical account of their difficulties, perhaps representing the dominance of the bio-medical model in understanding and treating mental health difficulties in many contemporary western societies including New Zealand (Read & Sanders, 2010; Read et al., 2008).

Some young people described actively resisting medication, or having to covertly stop taking unhelpful medication, implying a distinct lack of choice. This may in part reflect that many of the participants experienced quite significant and chronic mental health issues. Alternatively, it could be indicative of a possible over-reliance on medical interventions in New Zealand (Elliott, 2017). Overall, the views of the young people in this study aligned more closely with existing research that indicates young people see medication as important and helpful (E.J. Leavey, 2009; Romano et al., 2010; Summerhurst et al., 2017), than studies in which medication is described as unhelpful and stigmatising (Buston, 2002; Bluhm et al., 2014). The views of the young people in this study may have also been influenced by their work in a mental health system which largely relies on psychiatric medication.

However, some of the participants who were the strongest advocates of medication also positioned it as most helpful when used in conjunction with other interventions, such as talk therapy. Talk therapy was mostly described as helpful by these young people, providing
the therapist was attuned to their needs and the focus of therapy adapted accordingly. CBT was the specific model of therapy named most often, which is unsurprising considering its dominance in the New Zealand mental health system (Te Pou o Te Whakaaro Nui, 2009). It was described as being helpful for some people; however, was also described as insulting, insensitive to trauma, and as one young person put it “it kept me alive but it never made me happy”. A small number of young people who had used services for several years reported that they had never been offered talking therapy, whilst others talked about the frustration of being on a “waitlist” for psychology for extended periods of time. Overall the diversity in young people’s views on talking therapy is reflected in the existing literature: while some studies indicate young people prefer concrete advice and problem-solving focused approaches (Buston, 2002; Day et al., 2006; Garland & Besinger, 1996; McCann & Lubman, 2012; Persson, et al., 2017), others have emphasised the importance of having space to talk freely and feel listened to (Gibson et al., 2016; Lynass et al., 2012).

Perhaps unsurprisingly, participants in this study also described both informal and formal peer support as playing a role in their recovery. Young people emphasised that these interactions were helpful because they were characterised by mutuality, acceptance and a genuine connection based on shared experience. For some, their own positive experiences of peer support services was constructed as motivating their decision to pursue it as a career. Working in peer support, and mental health more generally was described as providing people with a purpose, and offering a way to either give back to the services that supported their recovery, or to try to influence change in the services that had not been helpful. For some, this work also appeared to provide a way to give meaning to their own painful experiences.

Once again, young people emphasised that personal agency and taking responsibility was crucial to using professional support effectively. This finding fits with literature that
suggests young people don’t want to be forced into treatment (Gibson et al., 2016; Persson, et al., 2017) and that intrinsic motivation promotes better clinical outcomes than external motivation (Ryan and Deci, 2008). However, young people also described limitations on their ability to effectively exert agency and control in their interactions with services and professionals. This pattern of young people expressing an expectation that they should be active agents in their treatment, yet finding it difficult to exert any real control, has been described in other New Zealand research (Gibson & Cartwright, 2013). While some young people in the present study described successfully exerting control in overt ways to get their needs met by services, for others the outcome was far less positive and often involved dropping out of treatment despite being desperate for help. In the present context of high demand and limited funding for mental health services in New Zealand (Allan, 2018; Elliott, 2017), discharging someone due to “poor engagement” may appear to make sense at a service level. However it is far from ideal for the young person involved if their poor engagement represents dissatisfaction with the care they are receiving and an inability to ask for things to change.

**Implications**

Our role is not to judge who will and will not recover. Our job is to create environments in which opportunities for recovery and empowerment exist.

(Patricia Deegan, 1995)

This sentiment has guided the present research and is particularly useful to keep in mind when considering some of the practical implications of the findings.

Although a typology of recovery stories was identified, young people appeared to make sense of their experiences in unique ways and their conceptualisation of how their difficulties developed appeared to guide their recovery process. It is important to
acknowledge that these young people’s understanding of their problems may have been different at earlier stages of their recovery, and that tautologically, their treatment may have influenced their present day understandings of their difficulties. However, the importance of getting on the same page as young people and developing a shared understanding of the problems they are facing, came through extremely strongly. This suggests that clinicians and services need to work collaboratively with young people to develop an individualised approach to the care designed to support their recovery process. Taking the time to talk and listen to young people in clinical settings may be difficult in our current resource-poor mental health system, but may be crucial to the development of meaningful engagement.

The potential benefits of a collaborative approach were also highlighted by participants’ emphasis on personal agency. Therefore, fostering an environment in which young people feel like active partners in their interactions with services and professionals, would likely be more supportive of recovery than one in which young people are viewed as passive recipients of care. While this is likely to be true for adults as well, young people’s desire for autonomy occurs in a context in which there are significantly more constraints on their ability to make autonomous decisions and be active agents in their life. Therefore, young people may need to be more actively encouraged to voice their treatment preferences and be given genuine options around who they are working with and the type of intervention they can access. However, clinicians may also need to challenge ideas young people may have about being completely responsible for their health and wellbeing, and remind them that some of the things that happen to them are not their fault, to actively work against the discourse that implies their circumstances are of their own making. In more practical terms, services may also need to be better resourced to support the engagement of young people who do not have the support of their family, with more assertive follow up and support with practicalities such as transport to sessions.
Experiences of psychological distress, and subsequent diagnoses and use of psychiatric medication, appeared to have a considerable impact on these young people’s identity. There was a strong sense that some mental health diagnoses are more stigmatising than others, for example the difference between depression diagnoses compared to schizophrenia and personality disorder diagnoses. This perhaps reflects a need for more public awareness about these types of diagnoses, similar to the Beyond Blue and Lowdown depression campaigns already running in New Zealand. While the diagnostic system may currently provide a way to decide who has access to mental health support in New Zealand, clinicians need to be aware of the potential impacts of this on young people’s developing sense of self. Thus an important part of recovery focused care may be to help young people develop an acceptable sense of self. This study offered support for suggestions that coherent personal narratives that emphasise meaning making and positive outcomes, may be somewhat therapeutic and support recovery (Lilgendahl & McAdams, 2011; McAdams, 2006; McAdams et al., 2001; McAdams & McLean, 2013; Tavernier & Willoughby, 2012). Thus, supporting young people to develop a coherent sense of self and to make meaning out of their mental health difficulties may be an important aspect of recovery-focused youth care.

Considering the importance of relationships and connection that participants described, helping young people to maintain or re-establish relationships with their friends and family may be particularly important. Young people also described genuine, warm, caring relationships with helping professionals as being supportive of recovery. However, those working in mental health in New Zealand, are currently working in extremely challenging conditions (Elliott, 2017). Underfunding, increased demand for services and a rise in acuity and complexity has led to those working in mental health reporting high rates of burn out and stress (Elliott, 2017; Stewart, 2016). This likely has significant implications for the capacity of those working in mental health to be emotionally attuned to their clients, as
well as the time available in which to build and foster genuine relationships. High staff turnover is also a common result in workplaces with high rates of burn out (Kahill, 1988), leading to young clients having to deal with frequent changes in their care team. Addressing systemic issues to reduce staff burn out and stress is therefore an important challenge for New Zealand policy makers to overcome, if they are to work towards fostering a more recovery friendly environment for our young people.

There are a number of structural aspects of New Zealand’s current mental health system that may make it difficult for young people to experience the relationally-focused care they described as important. The demarcation of services by age is one such characteristic of the current system. Aside from one individual, all of the young people in the study described their mental health issues developing well before the age of 18 and were still utilising mental health supports after their 18th birthday. Many had experiences of using both CAMHS and general adult mental health services, and talked about receiving care that was inappropriate to their age in both of these contexts. Due to the fluid nature of developmental stages, any service demarcated purely by age is unlikely to suit all young people. However taking a “youth approach” such as that implemented by the Headspace and Orygen Youth Health Services in Australia which offer a youth specific service for those aged 12–24 and 15–25 respectively (McGorry et al., 2013), would likely increase a service’s capacity to provide developmentally appropriate care and reduce the likelihood of a young person having to “transition” into adult services.

Following on from this, young people also described it being highly aversive having to tell their story to multiple people when first coming into a service or moving into adult services. Many New Zealand CAMHS run on the Choice Appointment Partnership Approach (CAPA) which often involves having different clinicians triaging, assessing and then providing interventions (Appleby & Phillips, 2013; York, 2017). This means that even if the
referral process runs as it should, a young person will have to tell their story three to four times. Finding a way to provide continuity of care within this process is not easy in an under resourced environment; however, considering ways to reduce the number of people a young person has to meet and disclose information to is strongly recommended. Likewise, the offer of brief psychological intervention was also described as off-putting for young people, in part due to concerns about being rushed to disclose information within a limited time. Although more funding is clearly needed, the reality is that health budgets will never “be enough” and the need for cost effective interventions is unlikely to dissipate. These young people’s emphasis on genuine relationships and desire for human connection, as well as specific comments about the helpfulness of mutual and reciprocal relationships, may suggest that therapeutic groups, skilfully and appropriately run, may offer a solution to this (Colom et al., 2003; McRoberts, Burlingame, & Hoag, 1998; Otto et al., 2000). The need for an individualised approach to care as suggested above, may also require the development of a wider diversity of talk therapy models being offered in public mental health settings in New Zealand.

**Future Research**

While the present research aimed to go some way towards filling a gap in the existing literature, it has also helped to illuminate future areas of research. In light of the previous comments regarding the specificity of this sample, eliciting recovery narratives from young people who are not working in mental health would provide a useful contrast to this research. It could also be interesting to perhaps create more structure around the age and stage of the participants. For example, a longitudinal research design could allow for narratives to be captured from young people between the ages of 14–16, again between ages 18–21 and finally after the age of 25, to explore how youth narratives may change over time and to
understand if and how young people understand their experiences as impacting the trajectory of their lives.

Perhaps one of the strongest reoccurring themes identified in this research was in relation to personal responsibility and agency. While young people did describe subversive ways of eliciting control over their treatment, this often led to disengagement with treatment, despite the young person feeling like they needed considerable support. Although Gibson and Cartwright (2013) have examined this in specific regards to counselling in New Zealand, there has been no research exploring this in relation to service use or recovery more generally. Integrating perspectives of service providers and informal supports such as friends and family may also add a richness to such a research endeavour. While not diminishing the importance of youth voices, it could also be useful to elicit the perspectives of professionals and service providers, to explore their views on what factors help or hinder their ability to provide the type of relational-focused care young people described as helpful.

**Strengths and Limitations of the Study**

In line with the epistemological underpinning of this research, the present study does not propose to be generalisable to all young people who experience mental health difficulties in New Zealand. Rather, the aim was to deepen our collective understanding of this currently under-researched topic. However, it is still important to highlight and consider the various limitations that exist in relation to the sample and methodology utilised when interpreting the findings.

It is important to note that the young people involved in this research represent a very specific group of people. Due to the requirement for participants to self-identify as being some way along their process of recovery, I wanted to speak to people with a shared experience at some point in their past, rather than sharing commonalities in the present day.
This posed significant recruitment challenges, especially considering commonly held concerns about stigma associated with disclosing mental health issues. This led to a decision to focus specifically on those young people who, at the time of recruitment, were working in mental health specifically because of their experience of mental health difficulties. As such, many of the participants had completed training and/or were working in environments heavily influenced by the adult recovery concepts outlined in this research (Mental Health Commission, 2012; Ministry of Health, 2012, 2018). These experiences likely influenced how these young people think about and consider their personal experiences and may have partly influenced the emphasis on personal responsibility (for example), which has been a core aspect of personal recovery since its inception (Chamberlin, 1978; Leamy et al., 2011; Mead & Copeland, 2000).

Working in mental health may have also influenced the tendency for these young people to provide very “psychologised” accounts of their experiences. This, in addition to my clinical psychology training, may have influenced the narrative typology, which could be understood as influenced by the concept of “psychological formulation”. However, the similarity between the present research and previous examinations of mental health recovery narratives (e.g. Jacobson, 2001) perhaps supports the possibility that the influence of “explanatory models” on recovery narratives, extends beyond those working in the field of mental health. Also, while the participants in this study were similar in terms of working in mental health, they did differ in terms of the types of difficulties they experienced, the types and location of services they used, and in regards to their ethnic and gender identities.

It is also worth keeping in mind that the young people involved in this research were self-selected and may have felt they had a “story to tell”. In other words, the study may have attracted young people who felt particularly negatively or positively impacted by their experiences, rather than those who understood their experiences as “just part of life” or who
felt more neutral about their contact with mental health services. In addition, the somewhat retrospective nature of this study, means that the way these young people understood their problems when they were acutely unwell was likely different from when they were interviewed. While retrospective accounts could be criticised as providing less “accurate” insight into people’s experiences, it could also been argued that personal narratives are what people keep and carry with them after the “real” experience is over.

An open, unstructured interview style was used to encourage young people to talk about the parts of their experience they felt were relevant, rather than being dictated by my own opinion about what was important to ask about. It was also hoped that this style would not disadvantage young people who felt insecure about expressing themselves in a written manner, or who may be put off by associations with school and test environments. However the dynamic between myself and the participants will have influenced the stories they told. While I worked hard to remain neutral throughout the interview process, at times it was difficult not to slip into the role of “therapist”, which likely shaped the stories to some extent. The participants’ perception of me as a future clinician and their employment in “the system”, had the potential for a conflict of interest when discussing more negative experiences with services. This possibility was foregrounded on occasions when young people prefaced a less positive reflection with “I don’t know if I am speaking out of turn” or clarifying that their name would not be mentioned in the research.

Multiple analytical processes were used as a way to flexibly and comprehensively explore the research questions, as it was felt that neither the narrative nor thematic analysis alone could adequately capture the essential aspects of the data. Despite this, there were still aspects of the data that were perhaps deserving of more attention that the present analysis provided. The influence of culture and role of informal supports were identified as two
particular areas; however, the scope of the present research did not allow for more in-depth analysis of these topics.

Member checking (Lincoln & Guba, 1985) in essence describes offering participants a method of response to transcripts or researcher interpretations of the accounts they constructed during the interview, so they can confirm their ideas or provide more material (Charmaz, 2006; Doyle, 2007). While member checking has been suggested to play a role in enhancing research validity (Doyle, 2007), it has also been highlighted that the method of member checking utilised must fit with the aim and theoretical underpinnings of a study (Cho & Trent, 2006). Birt and colleagues (2016) point out that asking a participant to check their transcript in research grounded in a positivist epistemology may enhance accuracy of data but not so in work guided by epistemologies that highlight the subjective nature of people’s realities. In this instance, asking participants to check transcripts could instead provide participants with an opportunity to reconstruct their narratives by altering and deleting parts they feel present them in a negative light or no longer represent their experiences. It was for this reason that member checking was not utilised in this research. However, had the scope of the research permitted, conducting a second interview in which the initial interview transcript or preliminary themes were used as a tool to facilitate the co-construction of new meanings, and perhaps validate previous interpretations (e.g. Doyle, 2007), would have added another layer of depth to the research.

Concluding Comments

Overall, the findings of the present study suggest that youth recovery is a highly active, personal process. While significant overlap appears to exist between adult and youth recovery, this study suggests that young people also face particular challenges. These challenges appear largely related to young people’s relative dependence on systems of care,
limitations on their agency and the significance of identity development during this stage of life. The young people in this study were able to quite clearly articulate what aspects of professional support they found facilitative of recovery. The current New Zealand mental health system may have to undergo some significant changes in order to operate in a genuinely youth recovery-focused way.
Appendices

Appendix A: Participant Information Sheet – Organisational Representative

PARTICIPANT INFORMATION SHEET (MANAGER/ORGANISATIONAL REPRESENTATIVE)

PROJECT TITLE: Looking back, making sense: Narratives of youth mental health problems and recovery.

NAME OF RESEARCHER: Rebecca Herald

I am training to be a clinical psychologist through The University of Auckland. As part of completing my degree (Doctorate of Clinical Psychology), I am doing research into how people make sense of their personal experiences of youth mental health difficulties and recovery. My project is being supervised by Dr. Kerry Gibson who is a clinical psychologist and lecturer at the School of Psychology at The University of Auckland.

Not enough is currently known about the lived experiences of young people, and even less is known about what recovery actually means for them. I think that people working in mental health who have had personal experiences of youth mental health problems and recovery offer a unique and valuable perspective.

HOW CAN YOU HELP?
I would like to request your permission to share information about this project with people working in your organisation/in your network and to request their participation in the research. If possible, I would also like to advertise the study on a noticeboard at your organisation’s premises, or on the organisation’s Facebook page.

It is very important that participation in this study is entirely voluntary. Therefore, whether or not a person working in your organisation/in your network chooses to participate or not, should in no way affect their employment or their relationship with the organisation.

WHO CAN TAKE PART?
I would like to talk to people who are currently working in mental health (e.g. peer support or consumer advisor roles) who have personal experiences of youth mental health problems and recovery.

WHAT IS INVOLVED FOR PEOPLE WHO CHOOSE TO TAKE PART IN THE RESEARCH?
I would like to interview participants for about 60–90 minutes. This interview will take place in person, and can be held at a place and time that is convenient to the participant. Interviews do not have to be held during working hours if this does not suit the participant or the organisation they work for—I can be flexible about this. Interview timing will be arranged via text, phone call or email. Before starting the interview the participant will be asked to fill out a consent form so that I am sure they want to take part in the research.

During the interview participants will be asked to talk in their own words about their personal experiences of mental health difficulties and recovery. The interview will be audio recorded and then transcribed by a professional transcriber, who will have signed a confidentiality agreement.

There will also be an opportunity for a follow up phone interview to reflect on the interview process, and for participants to discuss anything further that has come to mind since the initial interview.

RIGHT TO WITHDRAW FROM PARTICIPATION
If a participant changes their mind and decides not to take part in the interview, they can tell me and we can stop at any time. They do not need to provide any explanation for wanting to withdraw. Even if they complete the interview, they have up to two weeks after the interview to let me know if they have decided to withdraw from the study.

CONFIDENTIALITY
Everything discussed in the interview will be kept confidential. The only exception to this would be if I became worried about a participant’s safety (for example, if they said they were planning to hurt themselves), in which case I would be required to take action to ensure they remained safe.

Quotes from the interview may be used in research publications and in my doctoral thesis. However, extreme care will be taken to ensure that participants cannot be identified by quotes and their identity will also be protected through the use of a false name. No one, except for myself and my supervisor (Kerry Gibson) will know that they have taken part in the study.

As there are relatively few organisations working in this area, it is possible that readers may be able to guess the identity of the organisations involved. However we will not name your organization in any research.

DATA USE, STORAGE & DESTRUCTION
The data from the interviews will be analysed and the results of the study will be published in research publications and in my doctoral thesis. Participants can choose to receive a summary of findings from the study. You also have an option of receiving this summary of results and I would be happy to come and present the findings of the research to your organisation once the project is completed. The data from interviews will be kept for 10 years in a locked cabinet in the Department of Psychology. Participant names will not be attached to interview audiotapes or transcripts. Electronic data will be password protected. The consent form will also be kept for ten years and then destroyed, but in a separate locked cabinet. After this date, paper printouts will be destroyed and electronic data permanently deleted.

WHY BE INVOLVED?
You will have the opportunity to contribute to the development of knowledge that will further the ability to effectively support young people in their recovery. Individual participants will have the chance to reflect on and talk about their own lived experience and recovery, which I hope will be useful and interesting. The findings of this research may be directly helpful to yourself, individual participants and others in your organisation/network in regards to their work in mental health.
ARE THERE ANY RISKS INVOLVED IN THIS RESEARCH?
I am aware that actively reflecting on and talking about personal experiences of mental health difficulties may bring up emotions and memories that are upsetting. If participants do become distressed during the interview process I will support them during the interview. I will also have information with me about counselling and support services to pass on to them at the completion of the interview.

HOW TO GET INVOLVED?
If you are prepared to advertise this research at your workplace or through your network, please complete the consent form attached.

I (Rebecca Herald) can be contacted by phone or text at 022 625 2818 or you can email me at rher371@aucklanduni.ac.nz

---

**Researcher**  
Rebecca Herald  
Department of Psychology  
The University of Auckland  
Private Bag 92019, Auckland  
rher371@aucklanduni.ac.nz  
022 625 2818

**Supervisor**  
Kerry Gibson  
Department of Psychology  
The University of Auckland  
Private Bag 92019, Auckland  
k.gibson@auckland.ac.nz  
09 373 7599 ext. 88556

**Head of Department**  
William Hayward  
Department of Psychology  
The University of Auckland  
Private Bag 92019, Auckland  
w.hayward@auckland.ac.nz  
09 373 7599 ext. 88516

Thank you for your time and help in making this study possible.

For any queries regarding ethical concerns you may contact the Chair of the University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 ext. 83711. Email: ro-ethics@auckland.ac.nz

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 04/12/2015 FOR THREE (3) YEARS. REFERENCE NUMBER: 016449.
Appendix B: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

PROJECT TITLE: Looking back, making sense: Narratives of youth mental health problems and recovery.

NAME OF RESEARCHER: Rebecca Herald

I am training to be a clinical psychologist through The University of Auckland. As part of completing my degree (Doctorate of Clinical Psychology), I am doing research into how people make sense of their personal experiences of youth mental health difficulties and recovery. My project is being supervised by Dr. Kerry Gibson who is a clinical psychologist and lecturer at the School of Psychology at The University of Auckland.

Not enough is currently known about the lived experiences of young people, and even less is known about what recovery actually means for them. I think people working in mental health who have their own experiences of youth mental health difficulties offer a unique and valuable perspective, and I would like to hear your story.

HOW CAN YOU HELP?
If you are currently working in mental health, and you have personal experiences of youth mental health problems and recovery, I would like to interview you.

Being involved in this study is completely voluntary. If you have heard about this research through your manager or a colleague at work, it’s important for you to know that they have given assurance that your decision to participate or not will in no way affect your employment or relationship with the organisation.

WHAT IS INVOLVED IF YOU CHOOSE TO TAKE PART IN THE RESEARCH?
If you are selected to take part in the study, I would like to interview you for about 60–90 minutes. This interview will take place in person, and can be held at a place and time that is convenient to you. This will be arranged via text, phone call or email, depending on your preference. Before starting the interview you will be asked to fill out a consent form so that I am sure you want to take part in the research.

During the interview you will be asked to talk in your own words about your lived experiences of mental health difficulties and recovery. The interview will be audio recorded and then transcribed by a professional transcriber, who will have signed a confidentiality agreement.
There will also be an opportunity for a follow up phone interview to reflect on the interview process, and for you to discuss anything further that has come to mind as being important since the initial interview.

RIGHT TO WITHDRAW FROM PARTICIPATION
If you change your mind and decide you do not want to take part in the interview you can tell me and we can stop at any time. You do not need to provide a reason for wanting to withdraw. Even if you complete the interview, you have up to two weeks after the interview to let me know if you have decided to withdraw from the study.

CONFIDENTIALITY
Everything discussed in the interview will be kept confidential. The only exception to this would be if I became worried about your safety (for example, if you said you were planning to hurt yourself), in which case I would be required to take action to ensure you remain safe.

Quotes from your interview may be used in research publications and in my doctoral thesis. However, extreme care will be taken to ensure that you cannot be identified by your quotes and your identity will also be protected through the use of a false name. No one, except for myself and my supervisor (Kerry Gibson) will know that you have taken part in the study unless you tell them.

As there are relatively few organisations working in this area, it is possible that readers may be able to guess the identity of the organisations involved. However we will not name your organisation in any research.

DATA USE, STORAGE & DESTRUCTION
The data from the interviews will be analysed and the results of the study will be published in research publications and in my doctoral thesis. You can choose to receive a summary of findings from the study. The data from interviews will be kept for 10 years in a locked cabinet in the Department of Psychology. Your name will not be attached to the audiotape and transcript of your interview. Electronic data will be password protected. The consent form will also be kept for ten years and then destroyed, but in a separate locked cabinet. After this date, paper printouts will be destroyed and electronic data permanently deleted.

WHY BE INVOLVED?
You will have chance to reflect on and talk about your own lived experience and recovery, which I hope will be useful and interesting. This is also an opportunity to help other young people experiencing mental health problems by furthering our understanding of how to more effectively support young people in their recovery. I will send you a copy of the findings of the research once we are finished if you wish. This may be interesting to you personally, but may also provide you with insight relevant to your work in mental health. Once the research has been completed, I would be more than happy to come and present the findings of the study at your workplace if you wish. To thank you for your time and show our appreciation for your contribution to the research, I will also give you a $20 Westfield gift voucher.

TALKING ABOUT YOUR EXPERIENCES
I am aware that actively reflecting on and talking about your lived experiences may bring up emotions and memories that are upsetting. If you do become distressed during the interview process I will support you during the interview. I will also have information with me about counselling and support services that I can give to you at the completion of the interview. If you choose to have a follow up phone interview I will check in with you about how you have been since the interview and can offer support if needed.
HOW TO GET INVOLVED?
If you think you might like to take part in this research or would like to find out a bit more about it, then please get in touch with me (Rebecca) via the phone number or email address below.

**Researcher**
Rebecca Herald  
Department of Psychology  
The University of Auckland  
Private Bag 92019, Auckland  
rher371@aucklanduni.ac.nz  
022 625 2818

**Supervisor**
Kerry Gibson  
Department of Psychology  
The University of Auckland  
Private Bag 92019, Auckland  
k.gibson@auckland.ac.nz  
09 373 7599 ext. 88556

**Head of Department**
William Hayward  
Department of Psychology  
The University of Auckland  
 Private Bag 92019, Auckland  
w.hayward@auckland.ac.nz  
09 373 7599 ext. 88516

Thank you for your time and help in making this study possible.

For any queries regarding ethical concerns you may contact the Chair of the University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 ext. 83711. Email: ro-ethics@auckland.ac.nz

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 04/12/2016 FOR THREE (3) YEARS. REFERENCE NUMBER: 016449.
Appendix C: Consent Form–Organisational Representative

CONSENT FORM (MANAGER/ORGANISATIONAL REPRESENTATIVE)
This consent form will be kept for a period of 10 years.

PROJECT TITLE: Looking back, making sense: Narratives of youth experiences of mental health problems and recovery.

NAMES OF RESEARCHER: Rebecca Herald
NAME OF SUPERVISOR: Dr. Kerry Gibson

I have read the Participant Information Sheet and have understood the nature of the research and why I have been asked to assist with this. I have had the opportunity to ask questions and have had them answered to my satisfaction.

- I agree to assist with this research.
- I agree to an advertisement being placed at our premise and/or on our Facebook page.
- I understand that my assistance is voluntary.
- I understand that I should not put pressure on any of my employees/any person in my network to participate.
- I give my assurance that participation or non-participation will have no effect on employment or relationship with the organisation.
- I am aware that I will not be told if anyone from my organisation or network decides to participate in the research.
- I am aware that while my organisation will not be named in any research, it is possible that readers may be able to guess the identity of organisations involved in the study due to the relatively small number of organisations working in this area and thus small pool of potential participants.
- I understand that I am free to withdraw participation at any time if I am concerned about the process.
• I wish/ do not wish to receive the summary of findings (circle one).

• I wish/ do not wish for the researcher to present the findings of this research to my organisation at the completion of the study (circle one).

Name ___________________________

Email address (for summary of findings) _________________________________

Signature ___________________________

Date _________________

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 04/12/2016 FOR THREE (3) YEARS. REFERENCE NUMBER: 016449.
Appendix D: Consent Form–Participant

CONSENT FORM FOR INDIVIDUAL INTERVIEWS
This consent form will be kept for a period of 10 years.

PROJECT TITLE: Looking back, making sense: Narratives of youth mental health problems and recovery.

NAME OF RESEARCHER: Rebecca Herald
NAME OF SUPERVISOR: Dr. Kerry Gibson

I have read the Participant Information Sheet and have understood the nature of the research and why I have been selected. I have had the opportunity to ask questions and have them answered to my satisfaction.

- I agree to take part in this research.
- I understand that my participation is voluntary.
- I understand that my participation or non-participation will in no way affect my employment or my relationship with the organisation I heard about this research through.
- I understand that I will be interviewed for a period of about 60–90 minutes and have the option of a brief follow up telephone interview.
- I understand that I am free to withdraw participation at any time before and during the interview, and to withdraw any data traceable to me up to two weeks after the interview.
- I agree to be audiotaped.
- I wish / do not wish to receive the summary of findings (circle one).
- I understand that a professional transcriber who has signed a confidentiality agreement will transcribe the tapes.
- I understand that my interview data will be quoted anonymously in research publications and Rebecca Herald’s doctoral thesis.
- I am aware that while my organisation will not be named in any research, it is possible that readers may be able to guess the identity of organisations involved in the study due to the relatively small number of organisations working in this area.
I understand that interview transcripts will be kept for 10 years after which they will be destroyed.

Name ___________________________

Email address (for summary of findings) _________________________________

Signature ___________________________

Date _________________

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 04/12/2016 FOR THREE (3) YEARS. REFERENCE NUMBER: 016449.
Appendix E: Interview Guide

INTERVIEW GUIDE

At the start of the session, information about confidentiality will be discussed, including exceptions to this (concerns around safety and risk).

BASIC DEMOGRAPHIC DATA
At the beginning of the session, participants will be asked a few demographic and background questions, including:

- How old are you?
- What cultural group/ethnicity do you identify with?
- Identified gender?
- Current role and type of organisation you work for?
- What is your highest level of education?
- Have you done any other training relevant to your current role?

BODY OF THE INTERVIEW
In line with narrative methodology, interviews will conversational in nature to encourage participants to use their own words to tell their personal story. The interviewer will only ask questions to try and facilitate this process, and will not ask questions to direct the course of the interview.

To begin the interview the participant may be asked questions like:

- Can you tell me about your experience of being unwell as a young person?
- Looking back, how do you remember your experiences of being unwell as a young person?

As the interview progresses, further questions may be asked, such as:

- Looking back now, what stands out as the most important aspects of your experience
- How do you think those experiences impacted on you as a person
- When you think back to those experiences, how do make sense of what you went through?
- How do you feel when you look back on those experiences?
- How did having a mental health diagnosis effect you as a young person?
- Can you tell me about your experiences of using services as a young person?

If participants do not naturally lead into talking about recovery, the questions such as the following may be asked:

- What/who were your biggest sources of support while you were unwell?
- How do you see the concept of recovery relating to your personal experiences?
- How have you experienced recovery in your life?
- How do you make sense of where you are today?
Looking back, how do you understand the role mental health services in your recovery (if any)?

If participants need some more encouragement to elaborate on their accounts or to provide examples they may be prompted with questions like:

- Can you give me an example of that?
- Can you tell me a bit more about that?
- Can you tell me what happened in a bit more detail?
Appendix F: Transcriber Confidentiality Agreement

TRANSCRIBER CONFIDENTIALITY AGREEMENT

PROJECT TITLE: Looking back, making sense: Narratives of youth mental health problems and recovery.

 NAMES OF RESEARCHER: Rebecca Herald
 NAME OF SUPERVISOR: Dr. Kerry Gibson
 NAME OF TRANSCIBER:

I agree to transcribe the audiotapes for the above research project. I understand that the information contained within them is confidential and must not be disclosed to, or discussed with anyone other than the researcher and her supervisor(s).

Name ___________________________
Signature ___________________________
Date __________________________

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 04/12/2016 FOR THREE (3) YEARS. REFERENCE NUMBER: 016449.
Reference List


prophylaxis of recurrences in bipolar patients whose disease is in remission. Archives of General Psychiatry, 60(4), 402-407.


Jeffery, P. (2018). Don't marry me to a plowman!: women's everyday lives in rural North India. Routledge.


