HHS Public Access

Author manuscript

Psychiatr Rehabil J. Author manuscript; available in PMC 2023 March 01.

Published in final edited form as:

Psychiatr Rehabil J. 2022 March ; 45(1): 44–53. doi:10.1037/prj0000492.

A qualitative study on identity in individuals at clinical high-risk for psychosis: "…Why does it have to be one thing?"

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Abstract

Aim: Qualitative research can shed light on the subjective experiences of individuals at clinical high-risk (CHR) for psychosis, complement quantitative research, broaden our understanding of experiencing CHR, and inform intervention development. The aim of this study was to explore life experiences of individuals at CHR through qualitative research.

Method: Participants were 37 individuals at CHR (20 male, 17 female) aged 16 to 34 (M^{age}=23.32±5.26), and 16 healthy controls (HCs; 7 male, 9 female) aged 18 to 34 (M^{age}=25.37±4.05). Qualitative data were obtained through open-ended interviews (30–45 minutes). No a priori hypotheses were made, and thematic analyses were used to develop themes.

Results: Four major themes and one sub-theme related to identity were identified through the iterative thematic analysis: *defining a self-concept* (with a sub-theme of *creativity*), *identity development/formation*, *feeling different from others*, and *change from a former self*. Over 80% of the CHR cohort spontaneously discussed topics related to their identity, compared to 38% of HCs. HCs only reported content within the *defining a self-concept* theme, while the CHR group reported content within all themes.

Conclusions: The current study demonstrates that identity formation is a major process for youth in general and that psychosis experiences can make this process more challenging. CHR participants spontaneously brought up multiple themes related to identity in open-ended interviews, suggesting the relevance of this topic in this population. Clinicians should continue to

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probe identity-related concerns on an individual basis and research should focus on integrating this framework into the conceptualization and treatment of CHR.

Keywords

clinical high-risk for psychosis; early psychosis; identity; qualitative; self-concept

1. Introduction

Early signs of psychosis typically occur during adolescence and young adulthood—crucial developmental periods for identity development—and research has found that identity-related concerns are common among individuals experiencing early signs of psychosis (Ben-David & Kealy, 2020; Conneely et al., 2020; Friesen et al., 2021). However, little research has been conducted on identity development in individuals at clinical high-risk (CHR) for psychosis, a young and heterogenous group who experience attenuated symptoms of psychosis (Fusar-Poli et al., 2016). Comprehensive and needs-based programs, designed to identify and treat individuals at CHR, have been implemented worldwide (Catalan et al., 2020; Kotlicka-Antczak et al., 2020) and have been associated with positive outcomes, such as symptom severity reduction (Addington et al., 2019; Catalan et al., 2020; Fusar-Poli et al., 2020). Further investigation, however, is needed to identify more specific targets for intervention (Fusar-Poli et al., 2020; Salazar de Pablo et al., 2020). One such target is how psychosis-risk and early psychosis experiences might affect *identity*, as well as young peoples' general identity development and management (Ben-David & Kealy, 2020). Given the subjective, personal nature of identity, qualitative research is well equipped to uncover nuanced aspects of this process in CHR (Ben-David et al., 2014).

To date, qualitative research has shed light on the subjective experiences of individuals at CHR. Several studies have identified major themes around the anticipated anxiety about disclosing mental health problems, the importance of social support, and difficulties in interpersonal relationships (Byrne & Morrison, 2010; Welsh & Tiffin, 2012). One open-ended qualitative investigation found that some themes differ by gender (Ben-David et al., 2014), whereby males reported more hopelessness and passivity when thinking about the future, along with current and future concerns about their symptoms, prognosis, and recovery; on the other hand, females grappled with past trauma and current interpersonal relationships, but still maintained a focus on career and personal development. Another qualitative study with individuals at CHR found that self-concept/social image beliefs can play a significant role in mental health service use decision-making (Ben-David et al., 2019).

Overall, achieving a coherent and stable sense of *identity* is an essential developmental task during adolescence (Erikson, 1968). Early identity model theorists posited that a lack of distinctiveness and individuation during adolescent identity development could result in, or relate to, psychotic-like or psychosis experiences (Blos, 1967; Erikson, 1968; Kernberg & Caligor, 2005; van Doeselaar et al., 2018). Heavily influenced by a psychoanalytic perspective, these theorists proposed that a lack of "distinctiveness" from others and the world (e.g., being able to distinguish aspects of oneself from others, as well as distinguish external stimuli from oneself) could result in compromised reality testing and

a “psychotic personality disorganization”. Contemporary researchers (van Doeselaar et al., 2018; van Doeselaar, Klimstra, et al., 2019) have found that such distinctiveness is an important aspect of general youth identity development. Further, youth identity development typically involves processes of exploration (e.g., actively seeking and questioning various identities) and commitment (e.g., resolving identity crises and developing a sense of self), and is believed to occur on a four-part, developmental continuum: diffusion (low exploration/low commitment), moratorium (high exploration/low commitment), foreclosure (low exploration/high commitment), and achievement (high exploration/high commitment) (Marcia, 1966; Meeus, 2011). Although Marcia’s model of general identity development has yet to be applied to early psychosis research, adolescents with other mental health conditions have reported high levels of identity distress characterized by low exploration (e.g., more diffused and foreclosed identities) (Wiley & Berman, 2013) (sample primarily comprised of youth with internalizing disorders).

In a recent narrative review of studies (Ben-David & Kealy, 2020), only one of 17 studies was identified that summarized findings related to personal identity among individuals at CHR. In this Irish study of five individuals at CHR (Brew et al., 2017), the authors used a semi-structured interview to probe about experiences and understanding of symptoms, and life before the onset of the CHR state. The *identity* theme that emerged in this study related to participants’ struggles to differentiate between their symptoms and their identity, with participants incorporating various explanations for their symptoms, such as personality, genetics, and being an adolescent. These findings demonstrate the importance of qualitative research in order to better understand the development of identity, self, and psychosocial interventions for individuals with psychosis-spectrum experiences (Davidson & Strauss, 1992; Estroff, 1985, 1989; Lally, 1989; Strauss, 1989).

1.1 Current study

The purpose of the current study is to better understand the subjective experiences of individuals at CHR through qualitative research and add to the growing knowledge in this area. To date, few qualitative studies have been conducted with individuals at CHR, and such studies are typically limited by small sample sizes and methodological heterogeneity. Continued qualitative research is necessary in this area to complement quantitative research, broaden our understanding of experiencing CHR, and develop interventions. Given the emerging research in this area, no a priori hypotheses were made, and phenomenological procedures were used to develop themes. In our Conclusions section, we compare and contrast our findings to prior, formative phenomenological work with individuals at CHR (Ben-David et al., 2014; Brew et al., 2017). Data from similarly aged healthy controls (HCs) were also assessed for comparison. To date, there have been few qualitative studies that have been conducted with both individuals at CHR and HCs. By including a healthy comparison group, we were able to identify the themes that were specific to individuals at CHR and ensure that emergent themes were not a result of the age range of the study or a result of the interviewing method.

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2. Methods

2.1 Participants

Participants were 37 CHR individuals and 16 HCs recruited from the New York metropolitan area between 2018 and 2020 through flyers, online advertisements, and clinician referrals from outpatient clinics, schools, and the community. The Structured Interview for Psychosis-Risk Syndromes/Scale of Psychosis-Risk Symptoms (SIPS/SOPS) (Miller et al., 1999) was used for case ascertainment. Participants met CHR criteria if they had at least one positive item scored in the attenuated range (3–5) on the SIPS/SOPS, with symptoms beginning or worsening in the past year and occurring at an average frequency of once per week in the prior month[1]. Exclusion criteria for study participation included non-fluency in English, imminent risk of harm to self or others, history of threshold psychosis (as determined by Presence of Psychosis (POPS) criteria on the SIPS/SOPS, any major neurological or medical disorder, and an IQ of less than 70. The Structured Clinical Interview for DSM-5 (SCID-5) (First et al., 2015) was used to rule out substance/medication induced psychotic disorder. Exclusion criteria for HCs included adoption[2] and any SCID-5 diagnoses except specific phobia. Written informed consent was obtained from participants over the age of 18 and from parents of participant minors, who themselves provided written assent. This study was approved by the IRB at the Icahn School of Medicine at Mount Sinai.

2.2 Qualitative Interviews

Qualitative data were obtained through open-ended interviews conducted by one of five interviewers who were trained by co-author LD, an expert in phenomenological research methods. Interviews were conducted in private research rooms within the research lab (part of an academic medical center) with a trained interviewer. All participants were told the purpose of the study was to understand language patterns and emotion recognition. Audio-recorded interviews were transcribed and de-identified before qualitative analysis. Each interview lasted between 30–45 minutes and started with the interviewer asking, “How have things been going for you lately?” There were no other predetermined questions. Following the initial prompt, the interviewer utilized reflective listening techniques that allowed participants freedom to choose the topics they discussed with the interviewer (Davidson, 1994).

2.3 Data Analysis

Data analysis was modeled after established phenomenological procedures (Braun & Clarke, 2006; Davidson, 1994, 2003). The following steps were taken to establish the common themes and verify accuracy:

1. Each transcript was labeled with a unique ID number based on the chronological order of consent dates to anonymize participants.

[1]No participants met criteria for other SIPS syndromes.
[2]Adoption was included as an exclusion criterion because we were not able to reliably assess an individual’s genetic disposition for psychosis if they were adopted.

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2. Authors CS, ZRB, SNH, and JJM individually read the same five randomly chosen transcripts to familiarize themselves with the data.
3. Authors then conducted an independent search of the same five transcripts wherein each author manually generated a list of themes and identified patterns within the data.
4. The research team then discussed the themes they individually found as a group to generate a list of themes agreed upon by everyone. Themes that were not initially agreed on were discussed until a consensus was reached.
5. The remaining transcripts were organized and coded based on the agreed upon themes.
6. When each transcript was coded, the research team reviewed the excerpts identified within the themes, and organized a comprehensive thematic framework including the three overarching themes endorsed by CHR participants (i.e., agency, social function, and identity) and the sub-themes within them. Overarching themes for HCs included: desire to talk about their expertise and positive agency.
7. Each member of the team then went over the transcripts again to make sure agreed upon themes were accurately identified within each transcript.
8. Themes were defined and named to best exemplify what was captured in participants' own words and quotes that best exemplified each individual theme were extracted.

3. Results

One of the major themes that was identified in CHR through the iterative thematic analysis was identity. In this paper, we report only on the framework for identity-related content in order to provide sufficient detail for all subthemes within this theme. For the purpose of this study, identity was broadly defined as the character or personality traits individuals identified themselves as having or being. Identity related content was identified as language that an individual used to describe aspects of oneself including emotional, psychological, trait-like, and/or behavioral senses of self (Gecas & Burke, 1995; Jones & McEwen, 2000).

Participants included 37 individuals at CHR, aged 16–34 (M^{age}=23.32±5.26), comprising 20 males and 17 females. Gender was reported based on the individuals' identified gender. One CHR participant identified as transgender. CHR participants were ethnically and racially diverse; 27.1% Black, 21.6% Caucasian, 21.6% Asian, 13.5% identified as more than one race, and 16.2% did not feel they fit into any of these racial categories. Across individuals at CHR, 29.7% of individuals identified as Hispanic. Among the 16 HCs, participants were aged 18–34 (M^{age}=25.37±4.05), comprising seven males and nine females. Racial background in HCs was 43.7% Caucasian, 31.3% Asian, and 25% Black; of this group, 12.5% identified as Hispanic (there were no racial or ethnic differences in identity themes). There were no sex differences (female %, CHR vs. HC = 45.94% vs. 56.25%, $\chi_{1,53}$ =0.47, p=0.49) or age differences (U=377, p=0.12) between groups.

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Over 80% of CHR and 38% of HCs spontaneously discussed topics related to their identity. After identity was established as a major theme, four sub-themes regarding identity in CHR emerged: *defining self-concept*, *identity development/formation*, *feeling different from others*, and *change from a former self. Creativity* was classified under the *defining self-concept* theme as many individuals' identities were defined at least in part by their artistic abilities and creativity (see Table 1). HCs, on the other hand, only endorsed the self-concept sub-theme of identity. Thus, below we only report HC content in this domain.

Representative quotations are provided below and in Table 1. All identity related quotes can be found in Supplemental Table 1.

3.1 Defining a Self-Concept

Defining a self-concept emerged in over 50% of the CHR cohort, and refers to statements that encompassed beliefs about oneself and perceptions of how individuals viewed themselves. This theme was comprised of "I am…," "I have always been…," and "I was never…" type statements that described a part of the individuals' identity.

> "I've always been a kind of numb person that doesn't get extremely excited. Also that doesn't get really sad."
>
> [27]

> "So I'm actually a transgender person."
>
> [08]

Self-concept was the only identity-related theme that was captured in the HC transcripts as well as CHR transcripts. Approximately 38% of HCs described parts of their identity to the interviewer. Examples from HCs included:

> "I'm just a very in-tune person, I think, with the human condition."
>
> [09]

> "I consider myself an optimist. And I'm very averse to negativity and I'm pretty adaptable just in various settings."
>
> [12]

3.1.1 Creativity

3.1.1 Creativity—A sub-theme within *defining a self-concept* theme for the CHR cohort was expression of creativity. Creativity was defined as the belief of being a creative and artistic person. When talking about their identity, 35% of the individuals in the CHR cohort described creativity as a part of their sense of self.

> "I'm a creative person so I like to write. I like to listen to music."
>
> [05]

> "Because creative writing's been something I've been wanting to do since I was like 10. I just love writing. I love reading the creative writing books and everything."
>
> [32]

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3.2 Identity Development/Formation

Another theme that emerged in 50% of the CHR cohort was the development and formation of one's sense of self. To capture the full spectrum of identity development and formation, identity exploration was broadly defined as the desire to understand one's identity, wishes for the future, existential reflections/questions, and/or the recognition that one's identity is complex and multifaceted. Although this theme overlaps with defining a self-concept, identity is a broader construct related to sense of self and the *formation* of one's self-image.

Approximately 50% of the CHR cohort expressed wanting to understand who they were and also what aspects of one's self should define identity. Additionally, statements individuals made that were coded under this theme aligned with Marcia's (1966) four categories of identity development. For example, 12% of individuals within this theme expressed knowing who they wanted to be from a very early age (foreclosure), while 76% described still considering their options (moratorium) and 12% reported not actively pursuing any options (diffusion). No content related to identity achievement emerged.

> "I don't know. I want to do a lot of things but coming from a person who's like, "Do I like this? Do I like that?" I don't really know who I am because I never really got a chance to actually sit down and think because I've been in and out of the hospital since I was young. And to be honest, I thought I was going to die at a really young age. So when I passed that age, it's like what's next?"
>
> [10] (Identity development category: Diffusion)

> "That's like [what] you put on your business card or whatever, your LinkedIn profile is, I guess, the thing that is preeminent for most of us… I guess that's why I feel such deep anxiety about it. Like when you say, "I am X." Like, "I am a teacher. I am whatever." What's mine going to be? And why does it have to be one thing? I don't know. Yeah, it's hard."
>
> [24] (Identity development category: Moratorium)

3.3 Feeling different from others

Among CHR participants, 35% described a sense of feeling different from others, specifically their peers, in that their thoughts, behaviors, and experiences were unlike others'.

> "Even when people were to talk or have answers or something, I would think of something totally different. You see the color blue you would think sadness or whatever, but I would sometimes think I guess happiness in a way because the sky, just other stuff like that, and that's what makes me-- it used to make me question myself too. Why am I so weird?"
>
> [10]

> "I just kind of felt like I was just standing there and not having the same experience as everyone else."
>
> [19]

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3.4 Change from a former self

Approximately 40% of individuals in the CHR cohort expressed a sense of being a different person than they used to be. Furthermore, 35% of CHR participants who endorsed this theme highlighted their self-concept having changed as a consequence of mental health symptoms. Some examples of these symptoms included: mistrust of others, lack of motivation, depression, numbness, and panic.

> "I was always on the go when I felt good about myself. I mean, college started to be tough after a while and overwhelming, and I had to stop. But at the time, I felt proud of myself that I was doing something with my life. And I had goals and I was working towards them. Now, just all a disability."
>
> [35]

> "Before this [diagnosis], they knew me as someone who was always happy, make sure everybody was comfortable."
>
> [31]

4. Conclusions

4.1 Overview of Findings

Few qualitative studies to date have been conducted with individuals at CHR and, in particular, identity-related processes are not well-understood among such individuals (Ben-David & Kealy, 2020). The purpose of this qualitative study was to better understand the subjective experiences of individuals at CHR. Our exploratory study revealed a number of factors related to identity among individuals at CHR and demonstrated that identity development is a relevant topic for this group, with over 80% of the CHR cohort spontaneously discussing topics relating to their identity. Identity-related discussions were less common in the healthy control group (with only 38% of HCs endorsing this theme) and were also more circumscribed, including some areas but not others, like creativity. Qualitative data analyses revealed four major themes regarding identity in the CHR group: *defining a self-concept* (with a sub-theme of *creativity*), *identity development/formation*, *feeling different from others*, and *change from a former self.* The only theme identified for HCs was *defining a self-concept.*

Defining a self-concept, a specific aspect of identity development, captured definitive statements individuals made about their identity. For both CHR and HC participants, this included longstanding traits that were viewed to be permanent and integral in understanding their personal behaviors and choices. HCs and individuals at CHR chose both cognitive (e.g., "I'm actually a transgender person") and affective (e.g., "I've always been a kind of numb person") descriptions of their self-concept. Cognitive descriptions of one's self-concept were based on knowledge of one's self and perception of oneself, whereas affective components of one's self-concept referred to self-esteem and self-worth. Individuals also varied in what defined or was a central aspect of one's self-concept. For example, while some individuals chose their jobs or longstanding personality traits or their creativity to define who they were, others chose to define self-concept in terms of mental health symptoms.

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Overall, while self-concept also emerged as a theme for healthy controls, this process appeared to be more pronounced and nuanced for the CHR sample. In both groups, self-concept was described in similar ways comprised of "I am…" statements that reflected how one viewed oneself. There were no differences in the aspects of oneself HCs and individuals at CHR chose to define their self-concept, but individuals at CHR appeared to offer longer, more complex answers to illustrate their self-concepts (e.g., related to being "social;" see Table 1). In addition to the explanation that these identity concepts might be more salient for individuals at CHR, it is also possible that a higher level of disorganized communication among individuals at CHR (v. controls) may result in overelaborated or detailed responses (e.g. tangentiality) (Miller et al., 2003). The CHR sample was also a help-seeking group made up of individuals who have had contact with mental health services, so CHR participants may have been primed to open up during interviews in a clinical setting.

It is also possible that the experience of psychosis-risk symptoms and other mental health experiences for the CHR group primed this early self-concept development and awareness. There is a long history of research on the intersection of identity and psychosis (Estroff, 1989; Roe & Davidson, 2005) and the deleterious impact of identity disruptions (e.g., developing an "illness identity") on recovery outcomes for people experiencing serious mental health problems (Yanos et al., 2020; Yanos et al., 2010), primarily with adult samples. For example, multiple studies on the Illness Identity Model have found that internalized stigma (e.g., internalized stereotypes about mental illness) is related to reduced self-esteem, hope, and impaired relationships, and that a "mentally ill" identity can overtake other identities in this process (Yanos et al., 2020). Estroff (Estroff, 1989) has also discussed the potential for *identity engulfment* that can occur when experiencing serious mental health concerns such as psychosis, stating that, "Schizophrenia is an *I am* illness – one that may overtake and redefine the identity of the person" (p. 189). Through empirical research, this process of engulfment has been found to be a developmental process that may be more likely to occur in younger individuals and be influenced by particular characteristics (e.g., symptoms) and transitional events (e.g., hospitalizations) (Lally, 1989). Both Estroff (1989) and Lally (1989) implicate stigma in this process of role engulfment, acknowledging the potential negative consequences of mental illness labels and patients' efforts to resist and/or incorporate such labels into their self-concept.

Other researchers have expanded on this work and drawn on sociological conceptualizations of identity, describing how individuals can develop an *illness identity* in response to serious mental health concerns that is influenced by objective aspects of one's illness, one's meaning-making around their illness, and social stigma (Thoits, 2013; Yanos et al., 2010). In a narrative review (Ben-David & Kealy, 2020) summarizing 17 studies on identity in early psychosis, researchers identified several themes, including a disrupted sense of identity due to psychosis-spectrum symptoms or diagnoses, an exacerbation of other mental health symptoms due to identity changes (suicide attempts and negative mood states due to a sense of loss of self, defective self-identity, negative future selves), and the importance of restoring one's personal identity (incorporating early psychosis experiences into one's identity, acknowledging aspects of growth and recovery from these experiences).

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Similarly, approximately half of the CHR participants in this cohort also described trying to better understand themselves and define their identity. Statements coded under the identity development/formation theme explored the development of one's sense of self, as influenced by wishes for the future, perceptions of current self, and reflection of past selves (Wilson & Ross, 2001). During this exploration, participants acknowledged being complex, multifaceted individuals. Individuals not only tried to understand, explore, and define themselves, they also questioned which aspects of oneself would and should be considered part of one's identity. A few individuals, for example, discussed and questioned the singularity of identity and embraced a multidimensional sense of identity that could incorporate various aspects of oneself. Although typical identity development involves this incorporation of multidimensional features (Côté & Levine, 2014), this theme may be more pronounced for individuals with psychosis experiences and aligns with conceptualizations of psychosis as involving the fragmentation of mental experiences and disruptions of one's "self" (Bleuler, 1950; Lysaker et al., 2020; Sass & Parnas, 2003).

As noted, identity development involves exploration and commitment, and can be characterized by dimensions of diffusion, moratorium, foreclosure, and achievement (Marcia, 1966; Meeus, 2011). In the current study, half of the CHR sample made statements within the identity development/formation theme and these statements corresponded to Marcia's (1966) model, with moratorium being the most common category. This suggests an active consideration of identity options among many youth in this study, in contrast to findings in previous youth identity studies with non-CHR clinical samples from community mental health centers (Wiley & Berman, 2013).

Individuals at CHR also viewed themselves in the context of their peers or others, consistent with identity theory (Blos, 1967; Erikson, 1968; van Doeselaar et al., 2018) and general youth development research (Elkind, 1967; Steinberg & Monahan, 2007). Just over a third of participants described a feeling that they were different from their peers, which was exacerbated in social contexts. Individuals expressed instances in which their interpretations or responses to situations were noticeably unlike their peers. In some instances, individuals explicitly asked about the thoughts, feelings, and behaviors of others in a similar situation to see how differently they perceived or acted towards things, which helped them to understand themselves better. Some participants described feeling different from others due to a distorted view of oneself (e.g., of one's body/physical appearance). Compared to healthy controls, past research has found heightened self-consciousness and perceptions of discrimination (e.g., regarding appearance, age, skin color, religion) among individuals at CHR (Saleem et al., 2014), which may partially explain this finding.

Change from a former self was identified as the last identity-related theme. Forty percent of individuals in this cohort expressed being different, in one way or another, from the person they used to be. In most cases, participants at CHR described a time when they felt good about themselves and felt like they had control over their lives and choices, and compared it to their present experience of self, which included their mental health struggles. For example, one participant described how she no longer felt like a "New Yorker" given her panic and anxiety surrounding riding the subway due to paranoid feelings. Another participant, who had recently received a promotion at work and thought of himself as a

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"hustler," described how panic attacks and low mood led to a leave of absence from work. Other examples of change with regard to mental health symptoms included references to changes in energy, motivation, and focus, and how this impacted goal-directed activities and identity-development opportunities.

Compared to prior research on the impact of psychosis experiences on identity, which suggest that serious mental health experiences can overtake one's identity (Davidson & Strauss, 1992; Estroff, 1985, 1989; Lally, 1989; Lysaker et al., 2020; Sass & Parnas, 2003; Strauss, 1989; Yanos et al., 2020), our findings indicated that most participants described their self-concept more broadly by invoking a number of personal characteristics, including social identities (e.g., work, school), interests and skills (e.g., creativity), and self-evaluations (e.g., one's rationality). Although the majority of individuals did not define their self-concept in regard to their mental health, some participants discussed how mental health symptoms influenced their self-concept while other participants discussed how mental health experiences have changed them. These latter findings align with past research demonstrating the potential impact of mental health symptoms, stigma, and transitional events on one's identity (Brew et al., 2017; Lally, 1989), and deserve further consideration in future research with individuals at CHR.

4.2 Clinical Implications

Given that identity development is a major process for youth in general and that psychosis experiences can make this process more challenging for individuals at CHR, clinicians should continue to probe identity-related concerns on an individual basis and incorporate this into care planning. Based on the current research, a starting point for such inquiry may include questions related to our study's themes, though this should not be seen as an exhaustive list. It appears that individuals at CHR would like to speak about identity-related topics, and this focus would align with collaborative gold-standard treatments, such as Cognitive Behavioral Therapy (CBT) (Addington et al., 2019). CBT might also be used more directly to target unhelpful thinking patterns, such as for individuals at CHR who are "feeling different from others" or feel "changed from a former self." It is important to note here that the use of CBT and related intervention strategies in this context will likely need to acknowledge real changes these youth are facing, such as weight gain due to medication, loss of contact with peers, and onset of unusual experiences. If future research confirms that identity-related thinking is prominent among individuals at CHR, supplementary approaches such as Acceptance and Commitment Therapy (ACT) that encourage acceptance and mindfulness may also be beneficial (Reininghaus et al., 2019). Complementary or alternative strategies to support and validate identity changes for individuals at CHR might include facilitating peer support (Davidson & Guy, 2012; McGorry et al., 2019; Reilly et al., 2019) and creating more opportunities for individuals with lived experience to be meaningfully involved in services and research (Brown & Jones, 2021; Byrne et al., 2018; Desai et al., 2019; Jones, Atterbury, et al., 2021).

Overall, it is clear that more research is needed to determine how to best target identity-related concerns in care. In a recent study with over 300 early psychosis clinicians in Canada, 98% of clinicians agreed that personal identity was an important issue for clinical

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attention and 99% believed that schizophrenia-spectrum disorders could negatively impact identity (Ben-David et al., 2020). However, only about half of these clinicians expressed a high level of confidence in their ability to address identity-related issues, and less than a third of the sample believed current interventions adequately addressed personal identity. Interventions have been developed for a similar group of individuals (patients experiencing first-episode psychosis) to target how mental illness impacts identity (Best et al., 2018), but very few interventions to date have been developed to specifically target identity processes among individuals at CHR.

4.3 Future Research

Future research in this area might also consider assessing identity among individuals at CHR through contemporary research frameworks, including the narrative approach (i.e., developing a coherent life story), the dual-cycle approach (i.e., developing and evaluating identity commitments in breadth and depth), and the certainty-uncertainty model (i.e., reevaluating past commitments, such as those influenced by caregivers' beliefs) (Schwartz et al., 2005; Schwartz et al., 2013; van Doeselaar, McLean, et al., 2019). Specific to psychosis, future research should also consider how identity changes in psychosis can result from many different factors (symptoms, cognitive and social functioning, stigma, understanding of psychosis, meaning-making, personal growth and positive changes) (Conneely et al., 2020; Friesen et al., 2021). These approaches and others can help researchers and clinicians better understand how individuals at CHR define and understand their identity.

Related studies have also been conducted to better understand the experiences of individuals at CHR in regard to larger group identities, such as ethnic identity or mental illness identity, and this warrants further investigation: A strong ethnic identity has emerged as a potential protective factor against racial/ethnic discrimination for individuals experiencing attenuated psychotic symptoms (Anglin et al., 2018), but few studies have been conducted in this area according to a recent systematic review (Bardol et al., 2020). To date, findings on the relation of ethnic identity and early psychosis have been mixed and more work is needed to consider this factor in care. Citing Marcia's work (Marcia, 1966), one study with undergraduates found that low ethnic identity exploration was associated with more psychotic-like experiences, but only at high levels of aberrant salience (e.g., attributing significance to new experiences), highlighting the importance of considering moderators such as the nuances of psychosis experiences (Cicero & Cohn, 2018). In a similar vein, future research may wish to focus on the cumulative impact of disparities in access and quality of early-stage psychosis care among racial/ethnic minorities and how this may affect identity-related concepts as well (Jones, Kamens, et al., 2021).

Regarding mental illness labeling and identity, a recent systematic review (Colizzi et al., 2020) found that individuals at CHR endorse more internalized stigma than non-CHR psychiatric and healthy controls, and individual studies conducted in this area have highlighted the potential impact of mental health symptoms and labeling on identity for youth at CHR (Yang et al., 2015; Yang et al., 2019). Thus, future research is needed to evaluate how symptoms and various mental health labels (including CHR) may intersect with and affect one's identity development. Future longitudinal research may also help

determine correlates and predictors of why some individuals use more positive or negative traits to define themselves, and how this relates to community stigma and patient outcomes. This line of research would also open the door to inquiries related to potential protective factors and intervention mechanisms.

4.4 Strengths and Limitations

Although the sample was relatively large for a qualitative study, we were limited to a single, urbanized geographic region of the United States, albeit the racially and ethnically diverse city of New York. Further, we did not specifically ask about identity, but instead used an open-ended prompt. As more research is conducted in this area, more specific prompts and standardized tools can be used to understand identity for individuals at CHR.

It is also important to consider what identity means in different contexts. Although this is an ethnically and racially diverse sample of participants residing in New York City, which is home to many cultures, it may not be representative of identity perception in early course psychosis globally. Identity itself is perceived differently in individualist and collectivist cultures (Hofstede, 2001). Members of individualist cultures (e.g., Western countries like the United States) describe their identity using idiocentric terms like "smart" or "creative" while those in collectivist cultures (e.g., many Asian countries) describe their identity as tied to others and based in social system (Bochner, 1994; Hofstede, 2001). More work is needed to assess emerging psychosis in other cultures to understand both *if* identity perception is disrupted in these contexts, and what forms that may take.

In regard to sample characteristics, the sample comprised both adolescents and young adults, which can be seen as a strength. Unlike previous work (Ben-David et al., 2014), we did not find any differences in emergent identity related themes based on gender or age. Although our study also took place in New York City (Ben-David et al., 2014), our data collection occurred over ten years later, took place in a different part of New York City, and used different interviewers (and, as noted, a more unstructured interview prompt). Additionally, our study did not have the scope to consider identity development in this group in relation to specific developmental bands, which may be useful in considering how identity intersects with various developmental stages. Lastly, this was a help-seeking sample and future research should recruit and study identity among non-help-seeking youth at CHR as well, since differences may emerge between groups.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Funding information:

This study was funded by R01MH107558. Joseph S. DeLuca is supported by a T32 grant (1T32MH122394-01). Therese L. Todd holds a National Science Foundation Graduate Research Fellowship Program under Grant No. 1646736.

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Impact and Implications

This qualitative study demonstrates that identity formation is a major process for youth and psychosis experiences can make this process more challenging. Individuals at clinical high-risk (CHR) for psychosis spontaneously brought up multiple themes related to their identity, suggesting the relevance of this topic. Clinicians should continue to probe identity-related concerns on an individual basis and research should focus on integrating this framework into the conceptualization and treatment of CHR.

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Table 1.

Additional, representative examples of quotes from participants for each of the themes.

Identity Themes	Quotations from CHR participants	Quotations from HC participants
Defining a Self-Concept	"I've never really been sociable because I never really got the point of socializing. I see people socializing, and I'm just like, "Do we really need to socialize?" And that really shaped me today because I guess I wouldn't say I'm having trouble socializing, but just I try to avoid it." [10] "College isn't for me. School is not for me. School has never been for me. I haven't been the straight-A student, so college isn't for me. I knew that I was going into college, and then after the first semester, I kind of just failed everything. It kind of confirmed my suspicions. I'm not saying like, oh, I came in with the mindset of thinking like, oh, I'm going to fail anyway. I'm not even going to try. I did try. I tried my hardest to do everything the right-- well, I still end up failing, and I'm just like, you know what? It's not for me. It really causes a lot of stress, causes all of this, causes this and this and that, and I was just like, yeah. I don't want to do this anymore." [32] "I'm not a people person. I don't like spending—I don't like pretending I care about people. It has to be someone that cares or can pretend to care about other people, and I can't do that." [22] "I'm divided into two different people. I'm a rational person, and then I'm an irrational person." [36]	"I'm very social, so I like interacting with people and talking to people and being around people." [11] "This is different because I'm usually a morning person. am a morning person." [01] "I'm the kind of person that has a few friends, but they're very close to me, and they're very important to me." [14] "I like it because I'm a music person. I listen to music almost all day." [15] "Nerves are kind of an absence in my life. I never feel nervous or stressed to a large capacity. And I've just been like that the whole way." [12]

Identity Themes	Quotations from CHR participants
Creativity	"To now, it's really unknown, to be honest, because I now have interest to become maybe a singer, or be an actor, or to be a writer, to now also being a photographer." [13] "And I would just make music that I would want to listen to or that people can rap over or something or sing over. And I made a few albums, and yeah. But it definitely ties in with graphic design because I'll usually make the music off an image. So I would have the cover, like the album art first, and then I would make the music based off that." [28] "I invest my time mostly in songwriting, and screenplays, dance. Well, I want to make them a career. So for now, they're like investments and I'm putting a lot of hours into it. I'm relaxed at this state. I'm just letting it flow. I just wrote a screenplay, so I'm trying to get it out. It was very ecstatic because of the way I write. I have a notebook. I got inspired. And then I started journaling, and it sounded like a book. And then I'm like, oh my god, this sounds like it could be a movie." [06] "I rap and sing and do some movement and poetry and sometimes, depending on the venue, we project images behind me. And I have a few things that I've created just for that. So it's like a multimedia kind of experience." [21]
Identity Development/ Formation	"It was typical existential dread. I was like, who am I? What am I? Do I like boys? Do I like girls? Do I like anime? Do I like TV? Do I like newspapers? Do I like food? And then also, what am I going to be when I grow up?" [23] (Identity development category: moratorium) "I didn't really have a strong sense of identity. My identity was always what other people made it. It's weird. I'm still trying to figure all that out." [42] (Identity development category: moratorium) "The thing that terrifies me the most is this uncertainly in my own head because it's like your head makes you who you are. And your thoughts, your consciousness culminates who you are and what you do in life and stuff and your sense of identity. But if I'm not in tune with that, then what can I be in tune with?" [44] (Identity development category: diffusion) "I thought I was this one person, and then I was like, wow. I'm so many different people." [06] (Identity development category: moratorium) "I've always been someone that I can do anything, I don't need to be passionate about it. I'll do it. It's just I get so jealous about being [someone] who have this one passion. And I get so jealous. I wish I had this passion and I'm dying for it. I don't have that because I feel like I can do anything. And I'm interested in so many things that-- I don't know. That's why I feel like I don't know what to do next." [03] (Identity development category: moratorium)
Feeling Different from Others	"Yeah. It's, to be honest, really interesting to see their stories, and just to see mine, how they are similar, or how they are different." [13] "I feel like my whole system of thinking is so different from everybody else's." [43] "I don't know what I should tell people and what I shouldn't because I don't know-- yeah, I don't know what's normal and what's not. So I don't know. Something that I think is abnormal might not be abnormal to somebody else, or somebody that I think is totally normal is not normal to somebody else." [36] "I always had a different perspective on things. I always wanted to do things a different way." [41] "Some people feel the-- some people don't feel depressed as frequently as me, and so when I talk about depressing things it's not a big part of their life, so when I bring it up it has a lot more impact on them. Or it's very new to them. Whereas, for me, it's whatever. Because it's every day for me, so." [26]
Change from a Former Self	"I think that I was a very socially receptive person, maybe. And I don't know. I think I had more of myself to give. But now I don't. That kind of sucks." [43] "I would rather stay in my room or something. Or I used to go to music festivals a lot. And those would be super fun. I would look forward to them. And then the last one I went to was in July, and I just don't even remember any of it because I just remember being there and just feeling like, this is the least fun thing that I could be doing right now. And it used to be one of the favorite things that I would do with my friends. And it didn't make me excited." [19] "I'm certainly not the same person I was four years ago." [24]

Note. CHR=Clinical High Risk for Psychosis. HC=Healthy Control.

Full qualitative data can be found in Supplemental Table 1.

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