

Title: Construing journeys to recovery from psychosis: a qualitative analysis of first-person accounts

Short title: recovery after psychosis onset

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Abstract:

Purpose: To perform a qualitative analysis of the factors that were construed as salient in facilitating the process of recovery in the narratives of people with psychosis who had their first-person accounts (FPAs) published in an academic journal.

Methods: Computerized textual analysis was undertaken of 156 FPAs written by persons who had experienced psychosis and published in the Schizophrenia Bulletin between 1979 and 2020. Constructs were extracted from the FPAs and coded in terms of Mental health treatment and therapy, Self-management and Multiple factors; recovery processes (Connectedness, Hope, Identity, Meaning, and Empowerment), Struggles and Turning points.

Results: Psychosis impacted on individuals in profound and diverse ways. This was reflected in the different pathways to recovery included in the FPAs. Underlying the different pathways was the salience of re-engagement in the shared reality of others; development of a cohesive and positive self; empowerment through the use of selfmanagement strategies, and making sense of experience through reconstruing what was meaningful. Personal constructs identified in the FPAs provided insight into both challenges faced and alternative avenues of movement that were perceived as available.

Conclusions: Processes that support individuals re-engaging with the shared reality of others are central to recovery. Supportive relationships and fostering open dialogue were consistent themes across the different pathways that recovery journeys took. Establishing a meaningful lifestyle and recovering a positive sense of identity were a key challenge following psychosis onset. Appreciation of experiences contained in FPAs has the potential to enhance the effectiveness and humanity of mental health care.

Keywords: first-person accounts, schizophrenia, recovery, qualitative study, identity, treatment

Data availability statement: The data included in the paper and associated tables, which support the findings of this study are openly available in the cited papers available from the Schizophrenia Bulletin website <https://academic.oup.com/schizophreniabulletin>.

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Practitioner points

- Fostering re-engagement with a shared reality is crucial to supporting recovery from psychosis
- Recovery is a multidimensional journey that is built on clinical and functional stability across key life domains meaningful to the individual.
- Promoting therapeutic relationships that enable individuals to feel comfortable in disclosing their subjective experiences and that they can be understood is vital to appreciating these experiences and how individuals construe challenges and options open to them.
- The analysis of constructs in the current study highlights the importance of listening to and giving a voice to clients, in all aspects of their treatment and care.

1. Background

Psychosis can have a profound impact on individuals' sense of self and all aspects of their life, by disrupting their experiences as a unique person in the world (Lysaker & Lysaker, 2010). Two broad approaches have been identified that focus on the subjective experience of people who have psychosis, namely philosophical phenomenology and the recovery movement. The former is concerned with "structures of consciousness as experienced from the first-person point of view" and the latter with "individualized definitions of wellness and the processes which promote those" (Hamm, Leonhardt, Ridenour, Lysaker, & Lysaker, 2018).

Psychosis and self experience

Phenomenological approaches seek to describe what it is like to experience psychosis (Sass & Byrom, 2015). In reviewing various theories regarding hallucinations, the phenomenological approach has been summarised as not conceiving of hallucinations as isolated symptoms but "expressions of much broader transformations of one's relationship to oneself and the world" (Pienkos et al., 2019). Disturbances of the core self are central to phenomenological approaches though key theories differ in the emphasis placed on what aspects of self are disturbed as psychosis develops (Lysaker et al., 2018). Interventions based on phenomenology seek to enhance core aspects of the self.

Recovery and subjective experience

The recovery movement has become an increasingly important priority in mental health services worldwide (Slade, Williams, Bird, Leamy, & Le Boutillier, 2012). Defined as the attainment of a fulfilling life irrespective of symptom severity and functioning impairments (Bird et al., 2014), however, what constitutes recovery, who defines it and how it is

measured, are issues that have generated debate in a large and growing literature (Leonhardt et al., 2017). The nature of the relationship between personal and clinical recovery (Leendertse et al., 2021; Penas et al., 2021) and key factors that contribute or impede recovery and well-being (Andresen, Oades, & Caputi, 2003; Leendertse et al., 2021; Wood & Alsawy, 2018) are also debated.

While it was necessary from a paradigm shift and human rights perspective to shift the focus away from a narrower clinical definition there is a risk that clinical and functional improvement that is meaningful to individuals is minimised. For example, the Connectedness, Hope and optimism, identity, Meaning in life, and Empowerment (CHIME) framework (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011) does not include symptom response (Bird et al., 2014). Recent systematic reviews of recovery narratives highlight the multiple dimensions and individual differences through which recovery can be experienced and described (Llewellyn-Beardsley et al., 2019). Additionally, the importance of experiences related to symptoms, treatment and diagnosis have been emphasised (Walsh, Hochbrueckner, Corcoran, & Spence, 2016).

First person accounts (FPAs) of recovery

Essential to the process of creating recovery opportunities is an empathic understanding of the struggles of persons with mental disorders (Deegan, 1996). First person accounts written by people who have experienced psychotic symptoms constitute a rich source of lived experience of psychosis and recovery. Analysis of published FPAs allows access to these diverse individual experiences.

Personal Construct Theory and FPAs on recovery

Personal Construct Theory (Kelly, 1955), which stresses the role of subjectivity and self-disruptions as the basis of mental disorders, provides an integrative conceptual framework for understanding FPAs of psychosis and recovery. This theory was a forerunner of approaches in psychology that seek to understand human experience from the perspective of the experiencer (Kelly, 1955). Personal Construct Theory posits that individuals structure and anticipate the future using systems of bipolar constructs that are (in)validated and revised in the light of experience. Constructs are discriminations in term of likeness and difference that individuals make of their experience (e.g. people being construed as either friendly or hostile).

Kelly noted that underlying themes or dimensions will be repeated and that these can be detected by being alert to words that are “obvious signs of contrasts and linkages”, such as “buts”, “On the other hands” and “therefores” (Kelly, 1962/1996). The textual analysis that we present in the current study operationalised this by searching for contrast indicators (“*but*” or “*instead*”) and likeness indicators (“*and*”) to identify constructs in the FPAs. The challenges faced by people who have experienced psychosis are illustrated in two examples constructs identified by key-word-in-context analyses using the construct indicator “*but*”:

“On the one hand, I thought they came as a gift from God *but* on the other hand I feared that something was dreadfully wrong” (Anonymous, 1992). The author chose to elaborate the first pole, devoting several years to developing a theological system based around her definition of God. A second FPA illustrates, why at a point in time, seeking treatment was not selected as a preferred choice:

It crossed my mind to go to the hospital, *but* at the same time the call to go to Jerusalem seemed powerful and it almost felt like a betrayal to even consider the hospital because that would mean undermining my calling to go to Jerusalem and not taking that calling seriously (van der Pol, 2015).

Appreciation of the experiences contained in FPAs regarding the period after psychosis onset has the potential to inform practice through increased sensitivity to the diverse impacts experienced and what was found helpful to attain recovery by the individuals. Viewing the contents of FPAs as comprised of constructs in the Kellian sense, offers a window into alternatives (or avenues of movement) perceived as open to the respective authors. In the first instance, the choice between immersion in a world of psychosis versus seeking help and in the second, the choice between hospitalisation versus invalidation of the individual's "calling". Considering FPAs in these terms is an opportunity to explore them from a novel perspective, exploring in more detail the diverse journeys undertaken. While it may seem that these two individuals chose psychosis over treatment, in Personal Construct Theory terms, rather than simply seeing this as a lack of clinical insight, individuals are conceptualised as choosing the alternative which they considered more meaningful at that point in time.

1.1 Aim

The aim of this study was to identify factors construed as salient in facilitating the process of recovery in persons diagnosed with a psychotic disorder or who had contact with mental health services after experiencing psychotic symptoms. The sample was people who had their FPA published in an academic journal (*Schizophrenia Bulletin*). Objectives of the study were to examine (a) whether individuals construed medication and mental health treatment as

salient and (b) the salience of CHIME processes (Leamy et al., 2011) and other factors related to recovery.

2. Methods

2.1 Search strategy and FPA inclusion criteria

The Schizophrenia Bulletin has regularly published FPAs since 1979. A manual search of the journal website <https://academic.oup.com/schizophreniabulletin> for published and-in press FPAs was conducted in February 2019. For analysis purposes text files were required. Text file versions of FPAs published between 1979 and 2012 were obtained from an author who had previously analysed these FPAs (Fineberg et al., 2015) while FPAs from 2012 onward were copied from the original pdf and pasted into text file format.

The inclusion criteria for analysis were that a FPA contained content pertaining to the period after first treatment for a diagnosed psychotic disorder or psychotic symptoms. A broad definition was employed because the FPAs included examples of treatment provided before formal diagnosis was made as well as ineffective treatment due to misdiagnosis (e.g., someone diagnosed with drug abuse at first instance, and later changed to psychosis). However, where there was a period of psychosis without mental health treatment, only the period post treatment was examined. Of the 208 identified FPAs, 47 were excluded from further review. Reasons for exclusion were: Non-patient (e.g. sibling) FPA ($n = 37$), non-psychotic disorder ($n = 3$), retracted ($n = 2$), testimony regarding a deceased psychiatrist ($n = 2$), poem only ($n = 2$) and how to write a FPA ($n = 1$). Of the remaining 161 FPAs, 156 files contained content pertaining to the period after first treatment instigation. As the focus was on factors related to recovery, content related to symptom description or onset prior to

treatment was not included in the analysis, though have been examined in a companion study (Green, 2019). Author has been used as shorthand for “FPA author”.

2.2 Textual analysis

After manually reading the FPAs to identify which FPAs to include in the analysis, the method consisted of the following steps: 1) create a single corpus text file from the FPAs; 2) case, punctuation and unwanted whitespace removal; 3) identify constructs relevant to the study aims through key-word-in-context analyses which included contrast and likeness construct indicator words, 4) manual review of results to identify themes and exemplars of these themes and 5) coding of exemplar constructs. Figure 1 summarises the methodology employed.

Computerised textual analysis encompasses a range of methodologies, such as word frequency counts, word co-occurrence and key-word-in-context analysis (Gries, 2016). A key-word-in-context analysis employing the Quanteda package (Benoit K et al., 2020) was undertaken, based on 25 words pre and post the selected keyword. The larger number of keywords and context, compared to previous research (Green, 2016) was utilised after a preliminary analysis identified diverse use of words by individual authors and that constructs were expressed in longer sentences rather than short phrases. The longer context allowed for a more nuanced approach to exploring words and their individual meanings.

The following contrast words were examined: general contrast (*against, alternative, alternatively, although, but, compare, compared, comparison, contrast, contrary, differ, different, difference, except, however, instead, nonetheless, not, nor, opposite, one hand,*

other, other hand, prefer, rather, this, though, our, unlike, versus, was, were and. yet), time related contrast (*after, before, earlier, later, previous and previously*), magnitude contrast (*less and more*). Similarity indicators utilised were: *and, alike, like, likeness, same, similar and similarly*. Throughout this paper these indicators are displayed in italics.

The identified constructs are conceptualised as representing how individuals made sense of their experiences. For example, construing medication, therapy or work as salient to recovery is to describe a pathway within the overall recovery journey. A pathway is not necessarily the sum total of an individual's experience but what was particularly salient at a point in time. Salience is also assumed to be indicated by the recurrence of a topic or the author stating it was important to them. The identified constructs are how these pathways that were taken during the recovery journey were perceived.

Following the key-word-in-context analysis output for each individual FPA was manually reviewed to identify constructs that reflected the themes in that FPA. Because of the large number of indicator words employed, a construct might contain several keywords, hence generating a large amount of overlapping output. The collective output was then reviewed to identify recurring constructs and themes, as well as construct exemplars. A coding scheme and instructions (available as supplementary data) was developed by BG. Categories were developed deductively (e.g. CHIME processes) and inductively, based on recurring themes (e.g., mental health treatment, turning points, struggles and multiple factors).

Construct exemplars from these categories were selected by BG for coding based on the following criteria: recurrence within or across FPAs, typified key features of the category, reflects the range of constructs within a category and sampling to ensure constructs

representing all categories were included for coding. The 101 coded constructs came from 55 authors (12 were anonymous), which was 47.8% of all the authors. There were a number of reasons regarding why coded constructs were drawn from fewer than half of FPAs. All FPAs included construct indicators. The reason for not coding more texts varied: 1) in some instances an author wrote more than one FPA and constructs were repeated across the FPAs, 2) shortness of the FPA content resulted in a limited number of constructs and 3) repetition of content, such as constructs regarding medication.

These constructs were then independently coded by HGM and another coder, JB. Intercoder agreement was examined with the Various Coefficients of Interrater Reliability and Agreement (IRR) package (Gamer, Lemon, Fellows, & Singh, 2019) A multi-rater kappa of 0.53 was obtained for the 40 constructs initially selected for this paper. Given the relatively small number of constructs analyzed an additional 61 constructs were coded. A similar level of intercoder agreement was obtained (0.52).

Overall, there was complete agreement for the coding of 48 constructs. Where two coders agreed (n=41) this was accepted as a consensus coding and where all three coders disagreed (n=12), a code was assigned after discussion between BG and HGM. Agreement per category was respectively: Empowerment (0.21), Multifactor (0.23), Meaning (0.29), Turning points (0.31), Identity (0.42), Self-management (0.50), Connectedness (0.65), Mental health treatment (0.68), Hope (0.69) and Struggles (0.82). Where all three coders disagreed this mostly involved the application of the Meaning, Hope, Identity and Empowerment categories. In part this was influenced by coder preference for a particular code, such as one coder more frequently using one particular code.

Statistical analyses were undertaken using RStudio (RStudio Team, 2020).

2.3 Ethical considerations

An analysis of 18 FPAs were presented at a conference in July 2019 (Green, 2019).

Subsequently, the first author was advised that if publication of results was to be undertaken it was advisable to seek review by an ethics committee. The study was approved on 13/12/2019 by the Royal Brisbane and Women's Hospital Research Ethics Committee (LNR/2019/QRBW/58119).

The authors acknowledge that there is controversy regarding research accessing data sources in the public domain, particularly where this data was generated for a purpose quite different to that of the research. Oxford Academic, the publishers of the Schizophrenia Bulletin, allow text and data mining of their publications, without the need for formal permission, if for data is used for “non-commercial purposes”(Oxford Academic, 2022). In the current instance, the research was consistent with the Schizophrenia Bulletin's rationale for publishing FPAs (which prefaced FPAs up to 2004) as well as the expressed aim of many authors to share their experiences and enhance mental health service quality. Published FPAs provide a knowledge base that affords mental health practitioners insight into the views and needs of people who have come into contact with mental health services.

It was important FPA authors would not experience harm as a result of citing their accounts. Regardless of whether an FPA was published anonymously or not, other than name no others potentially identifying information has been provided. The authors were also sensitive to not misrepresenting the views of authors. An important aim of the current research was to

explore what people who have received treatment for a psychotic disorder or psychotic symptoms construed as helpful.

3. Results

Authors varied in terms of whether they described their entire journey or focused on key recovery pathways. The subjective experiences they described reflected phenomenological considerations about how the core self was experienced as well as changes in self-perception, goals and what was meaningful. The FPAs were however not just about struggle but overcoming such experiences. In addition to the examples provided in the Results, additional construct examples pertaining to Responses to treatment, CHIME processes, Struggles and Turning points are provided in Tables 1-3.

Mental health treatment (Responding to symptoms)

Four broad pathways were described: medication and treatment service focused; therapy focused; self-management focused and multifactorial. As Table 1 indicates medication could be central to recovery. In contrast, for others learning to live with medication was a journey itself, in particular, finding the right medication(s) and managing side-effects. For others recovery occurred after ceasing medication (Table 2) and therapy might supplement medication or be construed as an alternative. Trust, consistency, feeling listened to and respected were central to whether staff were construed positively or negatively: “Oppressive doctors or therapists were not helpful, *but* the ones who respected my efforts at recovery were” (Anonymous, 2017).

Self-management consisted of strategies and activities construed as important to leading a better life and varied in whether they evolved from mental health treatment or were self-initiated. Self-management ranged from symptom management and relapse prevention strategies to lifestyle changes and psycho-social factors. Examples included: reasoning and evidence seeking, such as ‘a "four-step system" to question, recognize, counterargue, and replace delusions (Chapman, 2002); journaling or poetry and self-assessment; identification of triggers or early warning signs, including relapse sequences (Boevink, 2006) and inference patterns (Timlett, 2013); listening to others/reality testing; facing fears; mindfulness and self-compassion; faith; diet and exercise; self-help groups; seeking meaning in symptoms and initiating change through experimentation (Johnson, 2015); problem solving and breaking problems into smaller steps. Relationships, safe accommodation, employment and activity were all construed as crucial.

Multifactorial pathways were combinations of factors variously elaborated as a list or construed in terms of pillars (Rofè, 2009; Weiner, S., 2016), wheels of health (Anonymous, 2017), rules (Jepson, J., 2016) or stages, though these differed across individuals (Anonymous, 2017; Ellerby, 2016; Jepson, J. A., 2017). In these FPAs while medication was construed as the basis or necessary for symptom control it was but one of many factors associated with leading a better life.

Struggles related to psychosis

A notable feature of FPAs was the struggles faced across a range of domains including “Abuse –physical, emotional, spiritual, sexual, and financial; humiliation; belittlement; vulnerability; lack of credibility; reduced to a three letter acronym; stripped of dignity; denied

your own inner convictions, feelings and instincts ...”. This was part of the elaborated pole of being labelled as “chronically mentally ill” (Blaska, 1991). The post psychosis experience was exacerbated not only by loss of functioning but also loss of phenomenological certainty: “When I came to the realization that what I was convinced to be true and real for so long was everything but true and real, I found myself no longer able to be convinced of anything” (Kean, 2011).

Impact on the narrative self could be just as profound: “In my delusions, I had been a heroine on a mission; now that I was back on medication, I spent most of my days lying in bed, hating myself with a vengeance” (Stewart, 2018). Extreme negative self-construal including self-blame for being psychotic, feeling ashamed or feeling circumstances was punishment, was not uncommon. A major challenge was how to proceed after acute symptoms had resolved or following discharge. As one FPA noted ‘... there are no clues, no map, no road signs like “wrong way,” “turn here,” “detour,” “straight on.” And it’s dark, lonely, and very frightening. You want nothing to do with it, but your return to sanity is at stake’ (Payne, 2012). Further examples of construed struggles are reported in Table 2 and include struggles regarding treatment, loss of meaning and functioning as well as feeling not understood or to being able to communicate one’s subjective experiences.

Turning points

While change was often construed as incremental identifiable turning points were also described. Turning points included moments of insight as mental health improved, life

events that provoked a need to change or seemingly random events such as seeing something on television, supportive words spoken by a stranger or residential changes.

Connectedness with others

Many post psychosis journeys began with reconnecting with family, friends or the wider community either in terms of seeking help, support or re-engaging with the world of others. Social connectedness in itself was a challenging journey that crucially required entering into a shared reality with others. This required overcoming delusional concerns, anxiety, fears about stigma, discrimination and rejection, including negative responses by mental health staff. One author noted:

Many people with mental health problems hide their symptoms, their aberrant beliefs, and their voices to stay out of hospital, *but* this means that they are ostracized and that there is a lack of dialogue between mental health professionals and people with mental health problems (Gray, 2009)

while for another “I took what I thought be a terrible chance *and* spoke honestly with my doctor” (Weiner, S. K., 2003).

Support and social contact was often construed as lifesaving. One FPA noted: “... people close to me patiently took me in tow in the world familiar to them, hereby offering me time *and* support to recover, rediscover, and re-establish my relation to the world I shared with them” (Sips, 2019). Social connectedness performed many functions: “This created a lot of support, camaraderie, *and* friendship. It gave us a sense of community. This is very important because loneliness is the most disabling feature of schizophrenia”(Coleman, 2003) .

Hope

FPAAs described being sustained by others when they did not have hope. Maintaining or developing hope was especially important when the journey occurred over a long period of time or involved significant struggle as hopelessness was also part of FPAAs: “When I left the hospital, I felt as though I could do nothing. Reaching a goal wasn’t even an issue when getting out of bed *was* my greatest challenge” (Houghton, 1982). Nurturing hope was a journey in itself and could be a slow process based on incremental change: “For a while it was hope that propelled me forward *but* after several years of work that hope has developed into confidence” (Colori, 2018a). Hope was also nurtured by re-engagement in the world of others and reconstruing what was meaningful: “Living once again in my culture reminds me, then shows me, *and* finally convinces me that I do not need the Deep Meaning” (Hawkes, 2012). Living in two worlds and choosing between them was a central construct in this FPA. Hope required changes in perspective and was nurtured not only by family or professional support but also through embracing religious faith or working toward something that was considered personally meaningful.

Reconstruing Identity and meaning-making

Fundamental to recovery and meaning-making were issues related to identity. As one FPA wrote, “Recovery was, for me, *less* a matter of losing delusional convictions than of actively rebuilding my comprehension of the world and regaining my trust in how I perceive myself and others” (Sips, 2019). In addition to regaining a “constant reliable self” (Johnson, 2012) overcoming negative self-construals was central in recovery journeys. Self-acceptance and acceptance from others contributed to a more positive sense of identity: “In my case, I think

that overcoming a violated identity might also then help me grow in respect of who I am, instead of being at war with myself” (Ellerby, 2017) . Acceptance through compassion for oneself was construed as critical to this process. Another FPA noted: “... now I had an understanding of what caused my precarious circumstances, and I realized that it was *not* my fault or anyone else's fault. The guilt that haunted me disappeared, and I no longer felt so helpless” (Scotti, 2009). While self-acceptance was a personal experience it was also associated with social connectedness, either with a therapist or through acceptance by others: “Being accepted and valued as a worthwhile person and an effective human being makes me feel like I am *more* than my illness” (Anonymous, 2018).

Integral to re-affirming and rebuilding an identity was making sense of one’s circumstances. One dimension of meaning making was making sense of psychosis itself. Writing afforded a way to reconstrue experience and create purpose by assisting others and addressing stigma. For some, psychosis was construed as having opened up opportunities associated with changes in belief, perspective, behaviour and lifestyle. However, uniquely challenging was making sense of continuing to experience psychosis: “I have to learn how to dance with the schizo, how to step *and* maneuver in such a way that respects the illness and respects myself” (Johnson, 2012).

Meaning making was an active process which was manifested in a variety of forms, including embroidery: “By creating, an individual becomes something more than just ill *and* at the same time has an opportunity to be healed through the creation process” (Karlsson & Malmqvist, 2013). As another FPA observed: “For me, the process of recovery involves changing roles *and* life goals - it is an intensely personal transformation” (Anonymous, 2018) . Meaning making and agency and were intimately related in the poles “pill medicine” and

“personal medicine”: “Pill medicine is what we take, *and* personal medicine is what we do, both how we stay well and the reasons we find for wanting to stay well” (West, 2011).

Empowerment and agency

Reconstruing was central to journeys involving empowerment and agency. Agency was demonstrated in a variety of ways (Table 3). Individuals recognized the need to take responsibility and to be an active participant in their life, through taking small steps. An enhanced sense of agency was also acquired through obtaining information about mental health issues, skill development was seen to increase confidence and, effort and facing fears were also crucial in making progress. A key factor underlying these processes was: “Working helped me to focus outwards and get me outside of my mind because I was interacting and focusing externally *instead* of being locked in reverie” (Colori, 2018e) .

The journeys contained in FPAs were motivated by seeking to return to a previous level of functioning, avoiding a return to the world of psychosis or engaging in activities and creating new roles and purpose. An increased sense of empowerment or personal agency was central to these processes of change: “Sanity came through a minute - by - minute choice of outer reality, which *was* often without meaning, over inside reality, which was full of meaning” (Anonymous, 1992). Time and persistence were frequently construed as essential to the process of recovery. Time was important in relation to acceptance of being diagnosed, needing treatment, developing self-understanding and rebuilding a meaningful life. These journeys were about not giving up but persisting despite adversity.

Growth and change characterised many FPA journeys while others featured rebuilding after relapse. Underlying these journeys was the development of an increased sense of agency: “I have come to realize that our lives are precious *and* that life deserves our full effort and participation”(Reina, 2014). Importantly, the journey was no longer focussed on recovery from psychosis but living life not defined by psychosis.

DISCUSSION

In this study, we examined factors which were construed as salient in facilitating the process of recovery. Forty years of published FPAs written by people diagnosed with psychotic disorder or who experienced psychotic symptoms were analysed via textual analysis. The FPAs were a rich source of challenges faced and what individuals found helpful in their recovery? The novel feature of our analysis was examining FPAs in terms of their personal constructs. This provided insight into the alternatives authors considered open to them, as well as the implications of pursuing or not pursuing a particular alternative, as well as elaboration of constructs.

Mental health professionals can play a significant role in the social networks and lives of people who have experienced psychosis (Sweet et al., 2018). However, how services and treatment were provided was crucially important in the FPAs examined: “I am grateful for the compassionate care I have received. My doctor treats me as more than a biological machine (Murphy, 1997).” A challenge for mental health professionals is understanding what compassionate care looks like and how it can be provided. FPA authors construed factors, such as trust, providing hope and fostering self-help as important in promoting therapeutic relationships and pathways to recovery.

Social processes

A previous textual analysis of FPAs identified psychosis onset as a process of immersion in an inner world accompanied by withdrawal from the world of others (Green & García Mieres, 2021). In the current analysis, re-engagement with the shared reality of others was crucial to recovery. One FPA described this as beginning to see beyond self-absorption (Payne, 2012). Social factors such as interpersonal relationships and social inclusion are important to recovery (Tew et al., 2012). However, recovery has been characterised as embedded in social rather than individual processes (Price-Robertson, Obradovic, & Morgan, 2017). This latter framework emphasises “relational recovery” based on “interpersonal acts” rather than focussing on individuals being solely responsible for their recovery.

Another key finding of our study was the benefits of stability in key life domains, including accommodation and financial security, which were prominent in the FPAs and have been conceptualised as central to social recovery (Ramon, 2018). While work and study were simply a mean to an end for some authors, for others they were essential elements of a meaningful life. Further, significant distress was associated with poverty, unemployment and social isolation and the resulting experiences of being victimised and subject to stigma or exclusion.

Self-management

The FPAs also described diverse self-management pathways. A systematic review and meta-analysis reported self-management strategies provided alongside treatment as usual, enhanced outcomes across clinical, quality of life and functional domains (Lean et al., 2019). Self-management was also important for the sense of empowerment, hope and enhancement of

identity that was associated with increased agency and control. The self-management strategies and multifactorial accounts of recovery emphasized the need to adopt approaches that encompass and support individual's needs beyond treatment of symptoms, while also recognizing the importance of symptom control (Windell, Norman, & Malla, 2012).

Recovery and the self

A particularly moving aspect of the FPAs was the impact of psychosis on identity, in terms of a sense of self and the narrative self. Reestablishing a sense of self and what is real was a fundamental challenge for some FPAs. Although a uniquely personal experience the intersubjective context poses challenges regarding how to work collaboratively to facilitate a sense of self (Lysaker et al., 2020). Regarding the narrative self, many FPAs contained negative constructions of the self, including self-stigma. Self-stigma and unmet needs has been found to mediate the relationship between symptoms and quality of life (Chan & Mak, 2014). FPAs described living between the world of psychosis and the world of others, having lost a sense of self and certainty, self-blame, despair at changed life circumstances and trauma. Discussion of these experiences may be avoided by mental health practitioners (Federico et al., 2013) or not disclosed because of feared implications. The FPAs highlight the importance of seeking to construe how others see the world, what Kelly described as the sociality corollary, while also developing shared constructs, so as to explore personal meaning (Kelly, 1955).

Limitations and strengths

Some limitations need to be noted. First, published FPAs may not be generally representative of people who have experienced psychosis. The FPAs were retrospective, written by a cohort

of people who submitted an article to a professional journal. Secondly, the findings may be less relevant to populations unable to access treatment or recovery services, for example, people from developing or non-occidental countries with different concepts of recovery. Thirdly, we did not explore gender differences in the FPAs. Recent qualitative studies report that men and women may have different needs when recovering from psychosis (Firmin, Zalzal, Hamm, Luther, & Lysaker, 2021). Future analysis of FPAs should specifically explore the challenges and recovery journeys of men and women.

Fourthly, the method employed in the current research has been primarily been applied to text written by a single author. In contrast, the FPAs were written by over 100 authors with different styles, word usage and construct expression. For example, some FPAs expressed contrasts using “and” or the entire text was an elaboration of a single construct, revisited in various forms (Anonymous, 2019). Extensive manual review was required which highlighted that the method is best suited to a smaller number of texts which could be examined individually and in more detail. Further, a review of mental health narratives identified nine dimensions along which such narratives could be examined (Llewellyn-Beardsley et al., 2019). The current analysis featured constructs from narrative form (e.g. positioning in relation the clinical model), structure (e.g. trajectory and use of turning points) and content (e.g. protagonist) dimensions. Trying to code a construct which is multidimensional into a single category resulted in only moderate inter-rater reliability. Constructs could be located on multiple dimensions (for example, the protagonist may have described an upward trajectory following engagement with a peer support service) and it may have been more useful to code the constructs in terms of dimensions rather than a single category. Lastly, the cited exemplars in the current study reflect the authors’ judgment and clinical experience. It is acknowledged that the FPAs could be construed in alternative ways. This does not

invalidate the findings but acknowledges that such data are subject to alternative interpretations, which is consistent with Personal Construct Theory principles.

The study also has several strengths. First, it systematically analysed diverse FPAs from different countries and time periods, thereby being inclusive of heterogeneity of construing and experiences. Secondly, the computerised approach enabled a large number of texts to be examined and readily re-examined to ensure context was considered. Thirdly, the method was transparent in terms of how constructs were identified. Fourthly, a novel study feature was conceptualising the FPAs in terms of alternatives or avenues of movement facing the authors.

The intention of many authors was to enhance mental health treatment and show recovery was possible. Consequently, our findings suggest clinical implications. One fundamental implication relevant to psychotherapy, psychosocial approaches or medication prescription concerns the importance of engaging the patient, through developing trust, being sensitive to personal concerns and the meaning of events. Internal experiences were often not disclosed to mental health practitioners because of fear or concern about consequences, but also because questions weren't asked (Federico et al., 2013; Steele, Chadwick, & McCabe, 2018).

It was also the case that the impact or salience of experiences was not fully appreciated. This was particularly notable in relation to the significant distress associated with how the self was construed, in terms of loss of sense of self and negative construction of self. Interventions to assist the patient in reflecting about their (Green, 2019) phenomenological self and place in the world, that focus on integrating emotional experiences into adaptive forms of self-awareness and enhance self-acceptance have been identified as important in the literature but are not yet routinely implemented in clinical practice in people with psychosis (Lysaker et al., 2020) .

Finally, the FPAs contain valuable insights about how change can be facilitated. The importance of hope was a recurring theme. However, change was construed as requiring small steps, persistence and time. Change could also occur through chance outcomes or turning points, “small events” or “micro affirmations”, experienced by a patient as subjectively meaningful but not appreciated by an external observer as such (Topor, Bøe, & Larsen, 2018). In the journey of change, professionals, families, friends, peer workers and others were all construed as playing an essential role in supporting individuals in recovery.

In conclusion, the findings from the current study support previous research regarding the importance of symptom remission in persons who have experienced psychosis and its impacts. However, there was considerable diversity in the pathways to recovery. Often, they involved learning to live with symptoms and side-effects, as well as rebuilding hope, a meaningful life and a positive sense of self. Recovery was embedded in social processes, from first disclosing symptoms to developing and utilizing supports. Appreciation by mental health staff, family and friends of the subjective experience of people who have experienced psychosis can be critically important in enhancing the effectiveness and humanity of mental health care. Therefore, interventions more focused on recognizing this subjectivity should be tested in a more structured and explicit way in daily clinical practice in people with psychosis.

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Figure 1 – Analysis steps

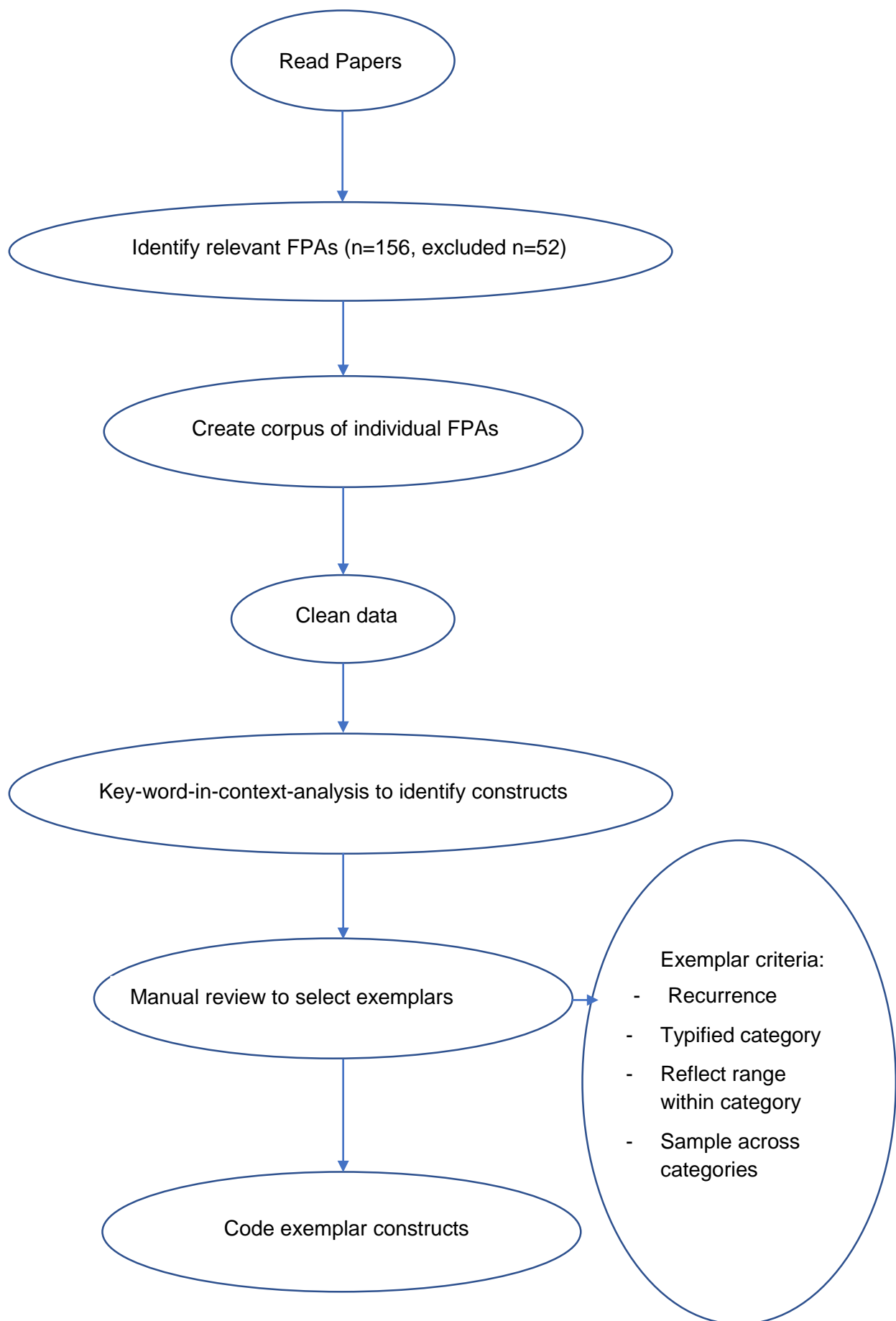


Table 1: Treatment journey constructs

<p>Medication</p> <p>“To get better, I did not perform any mental gymnastics (such as meditation or positive thinking), nor did I pursue any type of psychoanalysis. I simply took the medication, <i>and</i> I improved” (Snyder, 2006).</p> <p>When I returned to live with my parents, my antipsychotic was changed to risperidone. Within 3 days I woke up <i>and</i> it was as if a light had dawned across my life (Weiner, S. K., 2003) .</p> <p>Therapy</p> <p>“I decided to try psychotherapy <i>rather</i> than medication...” (Anonymous, 1989a).</p> <p>Self-management</p> <p>If my thoughts were at all disturbed , I would fall back on the poetry that I was now writing <i>and</i> nip off the offending thought train before it developed - a type of self-censorship perhaps (Tolton, 2004) .</p> <p>... and avoidance of crowded or loud places . My work ambitions are considerably different (once I would have said "lowered," <i>but</i> I no longer think of it that way). I have slowed myself down considerably , and changed my values so that relationships have become very important (Anonymous, 1990).</p> <p>You may think that changing behavior alone is not effective and that in order to obtain lasting change , you must understand why you are doing something. <i>But</i> this is not necessarily so. I can change my behavior much quicker than I can change my patterns of thinking ... (Johnson, 2015)</p> <p>My biggest coping strategy <i>and</i> pacification method of intrusive thoughts has been positive self-talk (Anonymous, 2019).</p> <p>I developed such a liking for psychotherapy’s results that I eventually made a journal and began self-administering psychotherapy <i>and</i> progressed far faster than I could if I waited for just one hour of therapy per week (Anonymous, 2016).</p> <p>By identifying these inferences , this can serve as an early warning system , which can then prompt me to question the inference <i>and</i> be much more skeptical toward it allowing me to spend more time assessing its credibility and gathering evidence that will to disconfirm this (Timlett, 2013).</p> <p>I do not willfully become psychotic, <i>but</i> there are many times that I feel so vulnerable that I need to pull away from the rest of the world and let my mind take over (Ruocchio, 1991).</p> <p>Multifactor</p> <p>What influences my mental stability? For me, this is family, work, social relations, <i>and</i> mental health care: Mental stability is similar to a ceiling that rests on pillars that symbolize external reality (Rofè, 2009).</p>

Note: Italics = contrast or likeness indicator words

Table 2: Struggle and Turning point constructs

Struggle

Medication is supposed to suppress my Deep Meaning and replace it with saneness. *But* no one tells me the feelings of loss I will feel in between the place of no meaning and not yet any meaning (Hawkes, 2012).

A few mere words cannot possibly convey to the reader both the intensity *and* the persistence of the pain I underwent in the process of fighting these inner battles (Gallo, 1994) .

I was not doing well. Although I tried day treatment programs, medications, shock treatments, *and* hundreds of hours of one-to-one therapy with my doctors, nothing helped me to gain any more control over my life (Lovejoy, 1982)

These 9 years have been filled with many disappointments. I've gone through long periods of unemployment. At 31 I am single *and* unable to support myself. I live with my parents. I am searching for a job that I will really enjoy (Herrig, 1995)

... in my memory, my hospitalization was an entombment; the medications were an embalmment. I walked among the living dead. It *was* not so much cruel as morbid and morose. It lasted 5 eternal weeks. In the real world the sense of death remained for years (Houghton, 1982)

Although I have gone through 5 psychotic episodes, resulting in 2 psychiatric admissions, recovery (and growth) *was* not the result of finding the right medication. For me, neuroleptics were even a hindrance in recovery ... (Sips, 2019).

Turning points

“My first break *was* seeing a "consumer" activist on a morning talk show “ (Anonymous, 1989b).

“I started crying because this resonated so strongly with my own experience **and** from that moment forward I tried to liberate my mind as much as possible” (Colori, 2018b).

“Realizing that I was not alone *was* a revelation. To this day I hear that one sentence in my head spoken from a beautiful person sitting next to me who came from some other place, whose life I knew nothing about...” (Salsman, 2003)

Note: Italics = contrast or likeness indicator words

Table4: CHIME process constructs

Connectedness

It may seem like a little thing, *but* having a good relationship with another human being makes all the difference (Gray, 2013).

Hope

I can't say my life now is as I would have expected it to be before my break, *but* as things have improved for me since then, I have some hope that maybe I can have a more satisfying life in the future (Anonymous, 1989a)

Identity

I question my realness. I realize that most people don't ever think about such things *and* don't ask themselves these questions. I am trying to piecemeal a " self " together (Johnson, 2012).

Meaning

All the pain and suffering of the past was not a waste because it has helped me to be *more* human in that now I feel I am a more compassionate and empathic person, and I can use that new enlightenment to help others (Scotti, 2009).

Empowerment

I write down a plan in steps so I can plainly chart my progress. *And* it is always encouraging to see progress (Johnson, 2015).

I could live independently and work again. In fact, the job and the house I found to share were also very important steps as I learned to take responsibility for my own life *and* to build a new life (West, 2011)

... you could change things *rather* than passively accept what was happening (Lovejoy, 1982).

Note: Italics = contrast or likeness indicator words

Construct coding instructions

CODE	CODE ABBREVIATION	KEY ASPECTS	CODING EXPLANATIONS
Connectedness	CCT	<ul style="list-style-type: none"> • Peer support and support groups • Relationships • Support from others • Being part of the community 	Enhanced social relationships with family or friends, peer support are coded here. Isolation and an absence of relationships without improvement are coded under Struggle. Support from a therapist or mental health clinician are coded under MHTx. Support to specifically cope with symptoms are coded under SMx.
Empowerment	EMP	<ul style="list-style-type: none"> • Personal responsibility • Control over life • focusing upon strengths • Expending effort to make change 	Empowerment is associated with increased personal agency. Here the focus is on increased life control, agency and change though – persistence, time required for change, progressive steps. Control specifically over symptoms is included under MHTx or SMx. Roles or activities that are primarily related to self-esteem are coded under ID.
Hope & optimism about the future	HOPE	<ul style="list-style-type: none"> • Belief in possibility of recovery • Motivation to change • Hope-inspiring relationships • Positive thinking and valuing success • Having dreams and aspiration's 	Positive statements about the future (e.g increased hope or confidence) as well as goals for the future are coded here. If negative experiences are also referred to but there is hope for the future, HOPE could be coded. Wanting to change, including motivations & role models can be coded here.
Identity	ID	<ul style="list-style-type: none"> • Rebuilding a positive sense of identity • Overcoming stigma • Dimensions of identity 	Whereas negative impacts on the self are coded under Struggle, Identity focuses on rebuilding a sense of self or a more positive self-perception. Increased self-knowledge, awareness or acceptance is coded here.
Meaning in life	MEAN	<ul style="list-style-type: none"> • Meaning of mental illness experiences • Spirituality • Quality of life • Meaningful life and social roles • Meaningful life and social goals • Rebuilding life 	Goals that are seen as important (e.g work or academic achievement), a new sense of purpose, deriving meaning from symptoms, seeking to inspire others or belief in a higher power are coded here. Attaining certain roles or enhanced quality of life is coded here. Specific references to the self and how it is perceived or experienced are included under Identity.

CODE	CODE ABBREVIATION	KEY ASPECTS	CODING EXPLANATIONS
Mental health treatment & therapy	MHtx	<ul style="list-style-type: none"> • Medication • Therapy • Treatment service/model 	Improvement in mental health or functioning is associated with medication, therapy or contact with mental health services – either alone or in combination. Negative consequences such as side effects, without any identified benefits are coded under Struggle.
Multifactor	MULT	<ul style="list-style-type: none"> • Multiple factors are identified that span several codes 	A list or several factors are identified that are associated with improvement in mental state and other areas. If only aspects of mental health treatment are listed, this would be coded under MHtx. MULT is applied when factors from a variety of domains are described (which can include medication or therapy). Listed stages of recovery would be included here.
Self management	SMx	<ul style="list-style-type: none"> • Early warning sign identification • Stress prevention • Reality check/evidence searching • Relapse prevention • Cognitive strategies • Activities (e.g writing, diet) 	This code is applied for strategies devised by or primarily applied by the author to enhance mental health & functioning. The application of strategies learnt in therapy could be coded here, however, the emphasis is on techniques or activities applied by the author, on their own.
Struggle	STR	<ul style="list-style-type: none"> • Psychotic symptoms or impact on the self • Functional impairment • Negative treatment effects • Poverty, isolation 	Problems directly associated with psychosis or secondary problems (e.g. treatment related or social problems) are coded here. Where one pole is negative and the other positive, but the overall feeling is positive, this would be coded under the code relevant to the positive factor.
Turning point	TP	<ul style="list-style-type: none"> • A life event (e.g. suicide attempt) • An insight • Information • Change in residence 	Turning points are identified as something that resulted in a significant change in an author's life trajectory or well-being. Medication instigation or change is usually coded under MHtx. Often these are chance or random events or experiences.