

**Possible Selves in First Episode Psychosis. A Mixed Methods Study.**

**Rachel Elizabeth Clarke**

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University of East Anglia

Faculty of Medicine and Health Sciences

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## **Abstract**

This study involved the application of possible selves theory to first episode psychosis (FEP) with the aims of understanding more about negative symptoms, functional outcomes and sense of self in FEP. A mixed-methods, explanatory sequential design was utilised. In the initial quantitative phase, a pre-existing data set of 80 participants allowed exploration of relationships between negative symptoms, functioning and possible selves. The qualitative phase, involving eight new participants, was then used to expand on specific findings from the quantitative phase, particularly how descriptions of possible selves might change as a result of experiencing FEP. Contrary to predications, relationships between elements of possible selves and negative symptoms were not found. Being optimistic about achieving possible selves was positively related to functional outcomes suggesting that positive self-beliefs may be important in functional recovery from FEP. Overall, findings also suggest that experiencing FEP does not necessarily have a negative impact on sense of self, potentially aided by hopeful, understanding and dependable social support. After experiencing FEP future fears about relapsing become more salient. These findings are discussed in relation to previous literature. This is followed by consideration of the theoretical and clinical implications of the findings along with suggestions for future research.

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# **1. Introduction**

## **1.1 Overview**

The onset of first episode psychosis (FEP) usually occurs in adolescence or early adulthood, a crucial developmental stage associated with developing a sense of self and envisioning the person one would like to become in the future. The onset of FEP at this stage has the potential to disrupt these key developmental processes. Early reparation of this damage is likely to be associated with more positive long-term outcomes and appears to be an important aspect of subjective recovery in FEP. Considering objective recovery, positive symptoms of psychosis often remit with pharmacological or psychological interventions whereas negative symptoms frequently persist and are associated with poorer functional outcomes (Austin et al., 2013). The aims of this thesis are to apply the concept of possible selves to FEP to understand more about both the impact of FEP on the developing sense of self and on mechanisms underlying negative symptoms.

This introduction begins with an overview of the nature of psychosis, specifically FEP, and definitions of recovery. It then examines in turn the concept of negative symptoms in FEP and the impact of FEP on sense of self, and explores why further research in each of these areas is important in improving outcomes for those with FEP.

Contextual information on the concept of possible selves (Markus & Nurius, 1986) is given, including an overview of previous research regarding the role of possible selves in motivation, lifespan development, chronic illness and interventions. Following this, the rationale for applying possible selves to FEP is outlined, with

particular reference to its potential applicability to negative symptoms and sense of self in FEP. The final section of the introduction outlines the research questions and hypotheses for this study.

## **1.2 Introduction to psychosis**

### **1.2.1 Defining psychosis**

The experience of psychosis can be one of the most upsetting, and debilitating of mental health difficulties involving disturbances in senses and perception, thoughts, emotions and behaviour (Davey, 2008). The two most widely used diagnostic manuals, the Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> Edition (DSM-5) (American Psychiatric Association, 2013) and the International Classification of Diseases, 10<sup>th</sup> Revision (ICD-10) (World Health Organisation, 1992), recognise a number of different psychotic disorders the most common of which is schizophrenia (Mueser & McGurk, 2004). A systematic review of the incidence of schizophrenia and psychosis in England found an annual incidence of 32 cases per 100,000 people for all psychotic disorders and 15 cases per 100,000 person for schizophrenia (Kirkbride et al., 2012).

It has become increasingly common for researchers and clinicians to divide the symptoms of psychosis into positive symptoms, experiences and behaviours that are present but undesired, and negative symptoms, experiences and behaviours that are absent but desired. Positive symptoms include hallucinations and delusions whilst negative symptoms comprise anhedonia, affect flattening and poverty of speech. This division was largely inspired by the work of Crow (1980) who proposed a two syndrome hypothesis of schizophrenia: type 1 schizophrenia being characterised by a

predominance of positive symptoms and type 2 schizophrenia by the predominance of negative symptoms. Following the hypothesis of Crow (1980), a further category of symptoms was proposed called, disorganised symptoms. These were proposed to represent features such as thought disorder, alogia and attentional difficulties (Liddle, 1987).

A meta-analysis of symptom factors in schizophrenia supported a three-factor conceptualisation with data from 10 studies yielding the symptom dimensions “positive”, “negative” and “conceptual disorganisation” as factors (Grube, Bilder, & Goldman, 1998). The distinction between positive and negative symptoms has been shown to be clinically significant and valid: studies have found positive and negative symptoms to show conflicting responses to some medications (Breier et al., 1994), to have different prognoses (Johnstone, MacMillan, & Crow, 1987) and found near zero correlations between measures of each (Kay, Fiszbein, & Opler, 1987). These findings suggest they are likely to be independent constructs with distinct pathologies.

### **1.2.2 First episode psychosis**

In East Anglia, the study area for this research, over the period of 2009-2012 the annual incidence of FEP was estimated to be 45 cases per 100,000 people (Kirkbride, Stubbins, & Jones, 2012).

The first onset of psychosis usually occurs during adolescence or early adulthood, a critical developmental period in terms of educational or vocational achievement, social roles, romantic relationships and sense of self. The onset of FEP at this time can potentially disrupt key developmental processes (Tarrier, Khan, Cater, & Picken, 2007) and is frequently associated with disruption to education and

employment (Goulding, Chien, & Compton, 2010; Harris et al., 2005; Mueser, Salyers, & Mueser, 2001). In a FEP sample in East Anglia, 50% of those referred to mental health services were unemployed, considerably higher than a rate of 8% in the general population at the same time period (Office of National Statistics, 2011).

Over the past fifteen years, the development of specialist early intervention in psychosis (EI) services have been prioritised in a number of countries, including the UK. Such services offer a range of evidence-based interventions, in an atmosphere of hope and optimism, to those aged 14 to 35 (NICE, 2014). The introduction of such services was driven by findings of an association between a longer duration of untreated psychosis (DUP) and poorer outcomes in terms of symptoms and functioning (Marshall et al., 2005).

Compared to generic services, EI services have been shown to improve a range of outcomes at 12 months, 2 years, and 5 years after entry into the service (Bertelsen et al., 2008; Craig et al., 2004; Norman et al., 2011). However, Bertelsen et al. (2008) found that improved clinical outcomes at 2 years post-entry were not sustained at a 5 year follow up. This study showed more favourable outcomes for secondary outcomes, “number of individuals living in supported housing” and “days in hospital” for those treated in EI services, as opposed to generic services at 5-year follow up (Bertelsen et al., 2008). Some support for the effectiveness of EI services was found in a Cochrane review (Marshall & Rathbone, 2011). However, the authors stressed the need for further randomised controlled trials and highlighted concerns about whether treatment gains from such services were maintained in the longer-term.

### **1.2.3 Recovery from psychosis**

The concept of “recovery” from serious mental illness (SMI), including psychosis, has been the focus of much research over the last 20 years, with a more optimistic view about the possibility and course of recovery emerging (Frese, Knight, & Saks, 2009). Debate continues over what is meant by “recovery”. Definitions fall largely into two categories: clinical/objective versus personal/subjective (Slade, 2009).

#### ***1.2.3.1 Definitions of recovery***

##### *1.2.3.1.1 Clinical/objective recovery: “Recovery from mental illness”*

This definition focuses on the remission of clinical symptoms and improved everyday functioning (Slade, Adams, & O’Hagan, 2012). It is based on operationally defined and objectively measurable criteria and is comparable to recovery from non-psychiatric conditions, such as from a broken leg (Davidson & Roe, 2007). Such a clear way of defining recovery has obvious advantages from both a research and clinical perspective. However, whilst it is important to understand and investigate recovery in such terms, this view is potentially reductionist in appreciating what people are recovering from and individuals’ future hopes. Recovery often involves having to overcome many aspects of a potentially catastrophic experience, including stigma, discrimination, social exclusion and disempowerment in addition to recovery from the illness itself (Repper & Perkins, 2003).

#### *1.2.3.1.2 Subjective recovery: “Recovery in mental illness”*

During the 1980's, consumers began publishing personal accounts of their recovery from SMI from which a different focus to the meaning of recovery emerged. This became the basis of the recovery movement.

Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. (Anthony, 1993, p.17)

Here, the focus is on subjective aspects of the condition and the ability to live a meaningful and satisfying life, in the presence or absence of symptoms (Frese et al., 2009). This view of recovery has recently been adopted as the guiding principle for mental health policy, practice and services, representing a shift away from a 'treat and cure' service (Shepherd, Boardman, & Slade, 2008). In the UK, promoting recovery is central to “No Health Without Mental Health”, the mental health strategy for England (Department of Health, 2011) with recovery-orientated services focussing on the key recovery processes of connectedness, hope, identity, meaning and empowerment (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011).

Evidently, recovery is a complex concept encompassing objective and subjective aspects: it has been argued that the above approaches to recovery should be seen as complementary and that the best way forward would be a synthesis of both approaches (Bellack, 2006; Lieberman et al., 2008). Indeed, it seems important for



research to address all dimensions of recovery in furthering understanding and guiding holistic clinical practice. It should also be noted that both ways of conceptualising recovery are linked by the inclusion of psychosocial functioning as a key element (Bourdeau, Lecomte, & Lysaker, 2014).

The following sections will include references to both these dimensions of recovery in relation to FEP. Initially, the discussion will focus on objective recovery from FEP, with particular reference to negative symptoms as a barrier to achieving this.

### **1.3 Objective recovery from FEP**

The majority of FEP research has utilised quantitative methods to address recovery in terms of symptomatology and social functioning. In such studies, rates of recovery vary depending on the range of diagnoses included, the length of follow up and the exact criteria used to define recovery, with a recent systematic review by Jääskeläinen et al. (2013) finding a median recovery rate from schizophrenia of 13.5%. One difficulty with studies investigating the outcomes of psychoses is that they tend to utilise designs that bias samples towards those with poor outcomes, for example by focussing on those diagnosed with schizophrenia (Morgan et al., 2014). This gives an inaccurate picture of recovery from FEP.

This was addressed in a ten-year follow up study of 557 incidence cases of FEP where 54% cases overall (37% non-affective psychosis) were found to have been symptom free for two or more years (Revier et al., 2015). This is more encouraging than in previous studies. However, in distinguishing between symptomatic and social recovery, this study found comparatively poor social outcomes with approximately

22% of cases in employment at follow up, compared to rates of 49% and 67% in the general population in the areas studied (Morgan et al., 2014).

### **1.3.1 Negative symptoms in FEP**

Defined as the absence or reduction in behaviours that are normally present, the main subdomains of negative symptoms are blunted affect (including blunted expression and affect flattening), alogia (poverty of speech), amotivation (loss of volition), anhedonia (reduced ability to experience or anticipate pleasure), and asociality (social withdrawal) (Kirkpatrick, Fenton, Carpenter, & Marder, 2006). Investigating the prevalence of negative symptoms across the FEP diagnostic spectrum, Lyne et al. (2012) found them to be most prevalent in schizophrenia spectrum disorders but frequently found in other FEP diagnoses, particularly substance induced psychotic disorder and major depressive disorder. This indicates negative symptoms are a significant feature of FEP.

### **1.3.2 Negative symptoms and recovery from FEP**

The current direction of research in FEP parallels outcomes in more chronic samples: that negative symptoms are a core and often persistent feature that link to poor functional outcomes and quality of life (Austin et al., 2013; Henry et al., 2010; Milev, Ho, Arndt, & Andreasen, 2005; Rabinowitz et al., 2012; Strauss, Sandt, Catalano, & Allen, 2012; White et al., 2009). This is not unexpected considering the overlap of components of negative symptomatology, such as avolition and anhedonia, with vocational and social recovery (Cassidy, Norman, Manchanda, Schmitz, & Malla, 2010).

In a ten year follow up study, Austin et al. (2013) found negative symptoms,

both at baseline and at 1 year follow up, to predict objective recovery from FEP at ten year follow up. This study has a number of strengths compared to similar studies, including a larger sample size and long-term follow up. Furthermore, Austin et al. (2013) applied universally recognised definitions of recovery. However, almost a third of the original sample was lost to follow up and, overall, these participants had demonstrated higher levels of symptoms at baseline. Findings may therefore over-represent good outcomes.

A study by Ventura et al. (2015) found negative symptoms early in the course of psychosis to predict functioning at 12 month follow up and to be predictive of negative symptoms 8 years later. This suggests that such symptoms show remarkable stability. However, this is not a consistent finding across studies. A meta-analysis of longitudinal data in schizophrenia found negative symptoms to improve in almost all outpatient samples (Savill, Banks, Khanom, & Priebe, 2015). Austin et al. (2015) used Latent Class Analysis to construct symptom trajectories for a cohort of 496 people with FEP followed up over a 10-year period. This showed heterogeneity in the trajectories of negative symptoms across the sample. Almost half of the cases showed a response trajectory with a fifth of the cohort showing significant improvements in negative symptoms between two and ten years after diagnosis, suggesting that negative symptoms are not necessarily stable and change can occur even several years after being diagnosed with FEP. Poorer social functioning at baseline was associated with worse negative symptom trajectory (Austin et al., 2015).

One component of negative symptoms, amotivation, has also been found to independently predict functional outcomes in FEP after controlling for other variables, such as positive symptoms (Fervaha, Foussias, Agid, & Remington, 2013,

2015). Such findings suggest that motivational deficits are a particularly significant barrier to achieving functional recovery in FEP.

It has also been argued that interventions targeting functional and social recovery may improve or even prevent chronic negative symptoms, suggestive of a bidirectional relationship between functioning and symptomatology (Killackey, Jackson, & McGorry, 2008). When investigating the interrelationship between these variables in a FEP population, Álvarez-Jiménez et al. (2012) found, in line with other studies, that remission of negative symptoms at 8 month follow up was predictive of functional recovery at 14 months. However, when considering functional recovery and remission of negative symptoms at 14 months, only functional recovery predicted additional recovery or remission of negative symptoms. This suggests that realising functional recovery in the early stages of treatment might protect against the development of chronic negative symptoms. It may be that not achieving early functional recovery disturbs the development period in which career milestones and intimate relationships occur (Killackey et al., 2008) leading to a loss of protective factors and adversely influencing long term outcomes.

### **1.3.3 Current treatments targeting negative symptoms and functional recovery**

Treating negative symptoms has proved challenging, having proved resistant to pharmacological interventions and with few documented psychological interventions.

In a meta-analysis of 34 randomised controlled trials (RCTs) that utilised cognitive behavioural therapy (CBT) for psychosis, only two of the studies

specifically targeted negative symptoms with a further two targeting social functioning. However, this review found that CBT had an effect on such outcomes even when they were not the primary target of the intervention, reporting a mean-weighted effect size of 0.44 (Wykes, Steel, Everitt, & Tarrier, 2008). However, a more recent meta-analysis of CBT for psychosis (Jauhar et al., 2014) found a smaller effect of CBT on overall psychotic symptoms with the authors highlighting that more trials of specifically adapted CBT for negative symptoms were required to understand more about its efficiency.

One such study, a RCT of CBT specifically targeting negative symptoms was carried out by Klingberg et al. (2011). The CBT intervention was based on a cognitive model of negative symptoms by Rector, Beck and Stolar (2005) which postulates that repeated setbacks lead to dysfunctional beliefs including low expectancies for pleasure and success, a perception of limited resources, a defeatist attitude about performance, and negative beliefs about socialisation. Such beliefs contribute to the persistence of negative symptoms. In the RCT, Klingberg et al. (2011) compared CBT to cognitive remediation (CR), selected as a control condition as, at the time of the trial application there was no evidence to suggest CR was efficacious in reduction of negative symptoms. Participants in both groups showed a moderate improvement in negative symptoms but there was no significant difference in negative symptoms between the groups. The authors hypothesised that both interventions may have aided participants in experiencing pleasure and success and hence led to a reduction in negative symptoms.

Another RCT adapted cognitive therapy (CT) for 'low functioning patients' with schizophrenia (Grant, Huh, Perivoliotis, Stolar, & Beck, 2012). Here, the

treatment focused on setting and working towards goals that aimed to improve quality of life, independence and social relationships/reintegration. Compared to those receiving standard treatment, those receiving CT showed improvements in global functioning, motivation (as measured by the avolition-apathy scale on the Scale for the Assessment of Negative Symptoms) and positive symptoms. Such improvements were thought to be due to the CT targeting self-defeating beliefs that prevent engagement in meaningful activity (Grant et al., 2012).

Whilst these studies show some support for adapting CBT to target negative symptoms, research in this area is still in its infancy. Furthermore, all of the studies described above were carried out with chronic schizophrenia samples. In considering the efficacy of CBT for negative symptoms in FEP, Fowler et al. (2009) trialed a ‘social recovery-orientated CBT’: whilst negative symptoms were not the primary focus of the intervention, it aimed to improve constructive social behaviour, which is likely impacted by negative symptoms. The intervention focussed on instilling hope about the future and increasing positive beliefs about self and others (Hodgekins & Fowler, 2010). Compared to a treatment as usual group, those with non-affective psychosis in the intervention group showed a significant improvement in the time spent in constructive activity per week and PANSS scores. Furthermore, increased levels of activity in those receiving CBT were associated with changes in positive beliefs about the self (Hodgekins & Fowler, 2010), demonstrating the impact that self-beliefs and cognitions may have on functional outcomes.

This discussion highlights the importance of developing interventions targeting negative symptoms and improving functional outcomes. One aim of this current study is to understand more about mechanisms that might underlie negative

symptoms in FEP. A greater understanding will help in guiding the development of future effective interventions. This discussion will now give an overview of FEP and sense of self before returning to the issue of negative symptoms in FEP.

## **1.4 FEP and sense of self**

### **1.4.1 Impact of FEP on sense of self**

The onset of FEP usually occurs in adolescence or young adulthood (Kessler et al., 2007), periods widely recognised as crucial developmental stages involving psychological, social and physical changes. This is a time associated with consolidation of identity and developing a sense of self: a key stage in questioning “who am I?” (Rosenberg, 1985). Young people begin to develop more of a sense of their future possible selves (Harter, 1999). Different possible selves are frequently rehearsed in exploring different roles; typically seen in increasing autonomy, separating from parents and taking increased responsibility for behaviour (McGorry & Yung, 2003). Late adolescence usually sees the setting and achieving of educational and vocational goals and the development of close peer relationships. These relationships often help to sustain the exploration of identity alongside influencing attitudes and emotional wellbeing (Mackrell & Lavender, 2004). Successful exploration at this stage can result in young people emerging with feelings of control and independence (Erikson, 1968) and any disruption has the potential to have serious consequences in terms of social and occupational functioning, identity and sense of self.

Referring to the onset of FEP at this stage it has been argued that “the effects.. .. on the self and development may be potentially cataclysmic, causing derailment,

truncation, deflection or paralysis of the person's developmental trajectory" (Jackson, Edwards, Hulbert & McGorry, 1999, p. 271). This is hardly surprising considering the onset of a psychotic episode has typically been found to result in fear, confusion and, at least initially, as intense emotional and frequently traumatic reaction which may be further compounded by experiences of mental health services such as hospitalisation and restraint (Tarrier et al., 2007).

Considering the impact of FEP in relation to the self and others, Tarrier et al. (2007) found that as a result of the onset of psychosis, 77% of those assessed indicated disruption to their life, 60% had threatened future aspirations, 50% suffered some form of social exclusion and 53% had experienced stigma.

Young people encountering FEP must also grapple with having an illness label often associated with shame, stigma and failure and must cope with the impact of this on their overall sense of self (McCay & Ryan, 2002). There is a risk that the young person's identity is lost and replaced with a sense of self completely defined by the illness, a phenomena known as engulfment, for example shifting from "having" schizophrenia to becoming "a schizophrenic" (Estroff, 1989).

Research suggests that how those with psychosis perceive their future has a significant impact on their physiological state. Considering the concept of engulfment, defining the future in terms of the "illness" has been associated with leading progressively more restricted lives, become increasingly demoralised and with low self-esteem and depression (Lally, 1989). Research has also shown that if a young person's appraisal of psychosis is marked by a loss of social goals, roles and status, despair and shame then the experience of post-psychotic depression is common (e.g. Rooke & Birchwood, 1998). Appraising psychosis as a threat to one's future



status is associated with post-psychotic depression (Birchwood, Iqbal, Chadwick & Trower, 2000).

#### **1.4.2 Subjective recovery from FEP and sense of self**

The majority of the research on subjective recovery from psychosis is concerned with those in the later stages of the illness who have undergone years of treatment. There is less empirical data regarding subjective aspects of recovery in those with FEP (Lam et al., 2011).

In those recovering from severe and enduring mental illnesses, self re-definition has been consistently highlighted as a central part of the process of subjective recovery (e.g. Davidson & Strauss, 1992). By analysing consumer accounts of recovery, Andresen, Oades, and Caputi (2003) attempted to define and clarify the process of recovery from schizophrenia. One of the four key processes that they identified was “reestablishing a positive identity” (p. 586).

Considering subjective recovery from FEP, a small number of qualitative studies indicate that this may differ from those with longer-term mental illness, particularly in relation to sense of self. The research suggests that subjective recovery in FEP is more about reshaping an enduring sense of self, in contrast to reconstructing a sense of self found in those with longer psychiatric histories (Eisenstadt, Monteiro, Diniz, & Chaves, 2012; Romano, McCay, Goering, Boydell, & Zipursky, 2010). This was a prominent feature in a qualitative study by Romano et al. (2010). The authors utilised a grounded theory approach finding that experiencing FEP did have some impact on sense of self but participants were able to preserve some aspects of their sense of self and this was not dominated by the illness. This may be because the FEP

client group appear to be less affected by identify stigma or prejudice and/or less likely to see themselves as “ill” (Eisenstadt et al., 2012).

Employing a focus group design, Lam et al. (2011) found those who had experienced FEP were largely optimistic about the future, with recovery focussed on learning lessons about future priorities and being able to think about a future where they were valued and respected. Maintaining a sense of hope and optimism about recovery is also at odds with the narrative of those with longer psychiatric histories, but is a consistent theme in the literature on recovery from FEP (Romano et al., 2010; Windell, Norman, & Malla, 2012). It was suggested that this might be due to the provision of specialist EI services for those with FEP that typically adopt a hopeful and optimistic approach to treatment, the younger age of the client group and the shorter duration of illness (Lam et al., 2010).

Participants in the study by Lam et al. (2011) placed little emphasis on symptom reduction as an important subjective aspect of recovery. This contrasts with other similar studies, for example, Windell et al. (2012) where 77% of the 30 participants identified symptom alleviation as an essential aspect of recovery. This finding is in line with recent research findings that negative symptoms in FEP, but not positive symptoms, are correlated with aspects of subjective recovery (Bourdeau et al., 2014; Norman, Windell, Lynch, & Manchanda, 2013). This is not surprising considering the consistent findings discussed previously regarding a link between negative symptoms and functioning (Austin et al., 2013). Perhaps symptom alleviation in subjective terms is important in allowing individuals to feel they can engage in meaningful social and occupational activities.

All of the above studies utilised a qualitative methodology with small sample sizes, crucial for gaining an enriched understanding of participants' subjective and phenomenological experiences. However, this methodology limits the generalisability of findings and this may account for the discrepancy in findings. Furthermore, many of the studies acknowledge that their samples may not be representative of the entire group of those who experience FEP: participants tended to be well engaged in treatment and had limited residual psychotic symptoms.

### **1.5 FEP summary**

There is a consistently reported association between negative symptoms and functional recovery in FEP and interventions targeting such symptoms are still in their infancy. Research developing understanding of models of negative symptoms is key in developing efficacious interventions that promote early functional recovery.

Experiencing FEP at such a crucial developmental stage has the potential to have a detrimental effect on an individual's sense of self. Reshaping a sense of self has been identified as an important aspect of subjective recovery in FEP and that a number of factors may be helpful in aiding this process. However, research in this area is limited and further understanding of how FEP impacts on sense of self may help in developing interventions that aid the reparation of such.

The discussion will now consider the concept of possible selves, examining previous research in this area and then linking the concept with the areas of FEP outlined previously.

## **1.6 Background to possible selves**

### **1.6.1 Defining possible selves**

As originally defined by Markus and Nurius (1986), possible selves are imagined scenarios for the self in the future and include hoped-for selves (selves that one would like to become), expected selves (the self that one believes will be realised) and feared selves (selves that one is afraid of becoming). They are considered to be a type of extremely specific and personalised goal structure. Furthermore, possible selves can be distally imagined - 'the self I will become as an adult', or proximal - 'the self I will become next year'.

Cognitive representations of the self in the future are socially constructed, reflecting specific cultural, environmental and social experiences (Hamman, Gosselin, Romano, & Bunuan, 2010). An individual's past experiences, such as prior performances and social comparisons may also influence possible selves (Cross & Markus, 1991; Hoyle & Sherrill, 2006). As they are yet to be realised, they are not limited by concerns over what may be realistic and so are more flexible than current or past representations of the self (Hoyle & Sherrill, 2006).

As they detail individually significant future goals, ambitions, fears and threats, possible selves serve to shape judgements about present behaviours depending on whether they move someone towards or away from the desired outcome or goal (Frazier & Hooker, 2006). They can therefore be understood as a key link between self-concept and motivation, serving to guide and regulate behaviour (Oyserman et al., 2004).

### **1.6.2 Previous research on possible selves**

Since it was first proposed, the theory of possible selves has been the focus of much research and linked to a number of outcomes including academic achievement and delinquency (Oyserman & Markus, 1990b; Oyserman & Saltz, 1993), health-promoting behaviours, (Hooker & Kaus, 1992, 1994), negative health behaviours (Aloise-Young, Hennigan, & Leong, 2001) and coping with life events (Barreto & Frazier 2012; Penland, Masten, Zelhart, Fournet, & Callahan, 2000). This research supports the idea that possible selves serve to motivate behaviour, facilitating outcomes in corresponding domains. The theory of possible selves has also begun to be used as the basis for interventions (Murru & Ginis, 2010; Oyserman, Terry, & Bybee, 2002). Overall, reviewing the literature on possible selves establishes that the concept has been applied to a wide range of populations, indicating its flexibility and applicability.

## **1.7 Functions of possible selves**

### **1.7.1 Self-enhancing possible selves**

Possible selves have been found to serve a self-enhancing function, whereby they serve to strengthen self-esteem, optimism and instil a sense of hope (Oyserman et al., 2004). Regarding this function, there appears to be no requirement for the imagined selves to be well elaborated or associated with a specified action plan: a positively framed future self merely needs to be brought to mind. Gonzales, Burgess and Mobilio (2001) found support for this idea. Participants, psychology students, were randomly allocated to two groups; one group articulated a future self-goal, whereas the other, the control group, did not. Those who articulated a goal

demonstrated elevated mood, enhanced wellbeing and were optimistic about achieving their goal compared to the control group.

The discrepancy between an individual's current self and possible selves has also been associated with wellbeing (Oyserman & James, 2011). Carver, Lawrence and Scheier (1999) asked participants to generate expected, hoped-for and feared possible selves and also to rate the similarity between each of these and their perceived current self. Those participants who perceived smaller discrepancies between their current selves and feared possible selves reported more symptoms of depression and anxiety, high levels of guilt and lower levels of contentment. As has been reported (e.g. Phillips, Silvia, & Paradise, 2007) this discrepancy between current self and feared future self was more important in terms of wellbeing than the discrepancy between current self and hoped for future self. It is not yet clear why this might be (Oyserman & James, 2011) although it has been suggested that it may be related to the notion that feared selves tend to be more concrete and based more on personal experiences than hoped for possible selves (Ogilvie, 1987).

### **1.7.2 Self-regulatory possible selves**

As stated previously, one of the proposed functions of possible selves is in motivating behaviour (Markus & Nurius, 1986): self-sacrifice and persistent efforts in the present day appear sensible when connected to the beliefs that future hoped for self-goals are achievable and feared self goals are avoidable. A number of studies have found possible selves to be associated with important behavioural consequences (e.g. Oyserman & Markus, 1990a). When compared to the self-enhancing function of possible selves, the self-regulatory function has been the focus of a larger volume of

research with many attempting to understand more about how and when possible selves regulate behaviour.

The most coherent framework for understanding how possible selves serve to motivate behaviour is Higgins' self-discrepancy theory (Higgins, 1987, 1996). This suggests that people are motivated to minimise the discrepancy between one's actual self and one's ideal/ought self: imagined ideal and ought selves act as guides that motivate behaviour. In other words, imagined future selves provide focus and incentives for action and when sufficient discrepancy exists between these and the actual self, self-regulatory strategies are implemented with the aim of reducing the discrepancy (Hoyle & Sherrill, 2006). However, there is still debate about the precise manner in which possible selves influence behaviour with, studies finding that certain conditions and factors can improve or hinder their motivational impact. The following discussion aims to highlight the most relevant points in this debate.

#### ***1.7.2.1 Elaboration of possible selves***

It has been argued that the extent to which possible selves elicit action is determined, to a large degree, by the level of detail of such selves. Ruvo and Markus (1992) argued that, “ - clearly elaborated possible selves and the strategies of realising them decrease the psychological distance between one's current state” (p.119). Indeed, goal attainment has been found to be improved when academic possible selves are well elaborated and linked to plausible strategies as a form of ‘roadmap’ to achieving desired selves (Oyserman et al., 2004). Oyserman, Bybee and Terry (2006) found that, in a sample of middle school students, when academically based possible selves (e.g. “ I hope to be a college student”) also contained information about how to achieve this (e.g. “I hope to be a better student and therefore

I must pay attention in class”) the possible selves appeared to demonstrate a stronger motivational influence on behaviour. It appears that the presence of a particular possible self is unlikely to exert a motivational influence unless it is linked with realistic strategies that guide an individual toward a hoped for or away from a feared possible self (Prince, 2014).

#### ***1.7.2.2 Influence of hopes and fears***

Considering motivational influence, there has also been much debate about the influence of the specific content of possible selves, namely the distinction between and relative importance of hoped for possible selves and feared possible selves. Such possible selves give rise to two modes of motivational regulation: hoped for possible selves give rise to approach goals whereby an individual strives to achieve a desired outcome, whereas feared possible selves lead to avoidance goals with an individual aiming to avoid an undesirable outcome (Bolkan, Hooker, & Coehlo, 2015).

A number of studies have found support for the motivational power of feared possible selves. In a sample of college students, those who were asked to write about their health related feared possible self were found to be more likely to participate in health promoting behaviours than those students who detailed their hoped-for health related possible self (Hoyle & Sherrill, 2006).

Generating feared health possible selves (e.g. “...becoming a diabetic”), as opposed to hoped for health possible selves, was specifically related to fewer symptoms of depression in a sample of older adults. This finding was taken to indicate that specifically focussing on disease prevention may motivate individuals to



maintain their health and this may indirectly influence their mood (Bolkan et al., 2015).

However, others have found hoped for possible selves or positively framed approach goals to be more strongly linked to motivation than feared possible selves. For example, Aloise-Young et al. (2001) found the number of positively framed expected possible selves to be negatively related to negative health behaviours in a sample of adolescents. Similarly, engaging in behaviours to support health and social goals was linked to those holding hoped for possible selves and not feared possible selves in older adults (Hoppmann, Gerstorf, Smith, & Klumb, 2007).

A number of ideas have been put forward to account for the discrepancy in findings surrounding whether approach or avoidance goals are most significant in changing behaviour: fear may only be a successful motivator when people are able to manage the accompanying threat (Rogers & Prentice-Dunn, 1997) in order to access the means or resources to avoid such fears (Bolkan et al., 2015). Those who lack such means may feel trapped by their feared selves. Such selves may then have a disorganising effect on behaviour and individuals may be less likely to take steps to evade them (Hooker & Kaus, 1994). This is consistent with the finding that, to be an effective motivator, possible selves must be linked with plans and strategies to attain or avoid (Oyserman et al., 2006).

### ***1.7.2.3 Balance of possible selves***

An extension of the original conceptualisation, and a shift from focusing specifically on the relative importance of hoped for or feared possible selves, is the idea that “a possible self will have maximal motivational effectiveness when it is

balanced by a countervailing possible self in the same domain” (Oyserman & Markus, 1990b, p.2). At a given moment when a positive possible self (e.g. of getting a job) is not particularly compelling, possibly because of competing short-term possible selves, the matched feared possible self of being unemployed can be recruited, and the desire to avoid this negative self should strengthen one's motivation to achieve the desired state or avoid the undesired state (Oyserman & Markus, 1990a). Support for this idea comes from research findings that adolescents with no hoped for self to balance a feared self were more likely to engage in delinquent behaviour than those displaying balanced possible selves (Oyserman & Markus, 1990b). Balanced possible selves give adolescents both a goal to strive for and an awareness of the costs of not meeting that goal. Thus motivation to attain the positive possible self and therefore avoid the negative self is preserved. Such individuals make more attempts to attain expected selves and avoid feared ones and are less likely to engage in delinquent behaviour.

Some studies have found an inconsistent pattern of results regarding the motivational impact of holding balanced possible selves. When investigating negative health behaviours in adolescents, Aloise-Young et al. (2001) found smoking and alcohol use were negatively related to balanced possible selves only in 8<sup>th</sup> graders and in boys but not girls. However, Aloise-Young et al. (2001) note that this may be due to them calculating balance across all domains of possible selves rather than a more targeted measure of balance: when investigating academic achievement researchers considered the balance between academic possible selves rather than overall balance over different domains (Oyserman & Markus, 1990b). In this area results have consistently found support for the motivational impact of balanced possible selves.

Furthermore, Ko, Mejia and Hooker (2013) found support for this idea in a sample of older adults. The study examined whether social possible selves, i.e. possible selves relating to interpersonal or family factors, hindered or assisted in making progress towards a social goal. They found that those with balanced social possible selves made significantly more progress towards social goals than those who did not have balanced social possible selves.

It should be noted that the original definition of “balanced” possible selves was based on pairing positively framed expected possible selves, rather than hoped for possible selves, with feared possible selves. This was based on the assumption that expected possible selves would be more likely to reflect reality whereas hoped for possible selves were likely to capture dreams and fantasies (Oyserman & Markus, 1990b). In more recent times, researchers have not adhered rigidly to this definition, with many defining and calculating “balance” by pairing hoped for and feared possible selves in the same domain (e.g. Frazier, Hooker, Johnson & Kaus, 2000; Ko et al., 2013). Aloise-Young et al. (2001) found the same pattern of results when calculating balance using both of these methods.

### **1.7.3 Methodological considerations**

Caution must be noted with all of the studies discussed above with regard to the motivational role of possible selves: they are all cross sectional rather than longitudinal. As such, it is not possible to determine if possible selves are an outcome of, or precursor for, particular behaviours or outcomes measured. When the concept of possible selves was first proposed, Markus and Nurius (1986) suggested that the relationship between behaviour and possible selves may be bidirectional whereby the formation of possible selves is influenced by past behaviour and such possible selves

direct future behaviour. The cross sectional design of the studies discussed also does not enable discrimination of the role of possible selves in the initiation or maintenance of related behaviour. Further longitudinal research is needed to overcome such limitations.

Despite it being almost 30 years since the concept of possible selves was proposed, the above research demonstrates that there is not a standardised measure of the concept nor is there a standard index of possible selves extracted from the measures used: some research involves listing possible selves (Aloise-Young et al., 2001), or ranking a list of provided possible selves (Hoyle & Sherrill, 2006). Additionally, studies do not typically offer a time frame for achieving or avoiding possible selves (e.g. “describe yourself 10 years from now”) or an arbitrary time frame is given, but these vary dramatically across studies (Hoyle & Sherrill, 2006). This makes it difficult to synthesise possible selves research and draw comparisons between studies.

### **1.8 Possible selves across the lifespan**

Across the lifespan, the content of possible selves has been found to change, demonstrating sensitivity to major developmental contexts across adulthood (Hooker, 1999). When examining possible selves in those aged 18-86, Cross and Markus (1991) found those in the younger age groups reported significantly more hoped for possible selves related to family (e.g. “.....marry the right person”) and occupation (e.g. “....to have a job I enjoy”) than older adults. In contrast, older adults listed hoped for possible selves related to physical health (e.g. “...being in good health”) and personal issues (e.g. “.....to be content”) the most often. Considering feared possible selves, all age groups listed feared selves related to physical health (e.g.

“.....being fat”) most often; however the older adults in the sample reported significantly more personal and physical health feared selves than the younger age groups.

Further lifespan research has corroborated the above findings, consistently demonstrating health related possible selves to become more salient as people become older, reflecting normal maturational processes (Frazier et al., 2000; Hooker & Kaus, 1992, 1994).

A large volume of research concerning possible selves has focussed on adolescents due to the importance of this stage in terms of identity development (Erikson, 1968). As they attempt to define “the self”, adolescents consider hypothetical versions of their future self-evaluating how desired and how likely they are for them (Knox, Funk, Elliot, & Bush, 1998). Research with this age group has also consistently found the content of possible selves to be closely linked to important developmental tasks, being focused on school and relationships (Oyserman & Fryberg, 2006). Furthermore, adolescents and young adults have been found to generate more possible selves than older adults, thought to be related to the importance of this stage in the development of sense of self (Cross & Markus, 1991).

The flexibility of possible selves across the life course allows individuals to disengage from goals that become irrelevant and create new goals that are focused on areas of life central to current identity and life story (Bolkan et al., 2015).

Furthermore, considering the link between possible selves and behaviour, holding developmentally relevant possible selves may be key in how individuals deal with life-span transitions and completion of particular developmental tasks (Markus & Wurf, 1987). For example, the increased presence of health related possible selves in older

adults may be important in motivating individuals to engage in or change their health behaviours in order to maintain their physical and psychological wellbeing for as long as possible. Research with this age group has found a strong relationship between holding health related possible selves and actual behaviours to avoid poor health outcomes or strive for good health (Frazier et al., 2000; Hooker & Kaus, 1992). Conversely, in an adolescent sample, those with possible selves not focused on the developmentally relevant task of academic achievement demonstrated poorer outcomes (Oyserman et al., 2004).

## **1.9 Possible selves and life events**

As well as being sensitive to developmental context, possible selves have also been found to be sensitive to stressful life events and transitions, such as parenting (Morfei, Hooker, Fiese, & Cordeiro, 2001) and illness (Morley, Davies, & Barton, 2005). Life events, whether positive or negative, may come to define an individual's sense of self, influencing their future and shaping how they cope with and adjust to the event. This may be linked with how the events become incorporated into their possible selves repertoire (Baretto & Frazier, 2012).

### **1.9.1 Possible selves and chronic illness**

Frazier, Cotrell and Hooker (2003) found possible selves to be extremely sensitive to living with a chronic illness, specifically those diagnosed with either Alzheimer's disease or Parkinson's disease. When compared to healthy older adults, those with Alzheimer's and Parkinson's were more likely to describe feared possible selves linked to losing their independence or becoming dependant on others. Reflecting the unique characteristics of each illness, different domains of possible

selves were found to be relevant, with Alzheimer's patients more likely to describe cognitive related possible selves and Parkinson's patients more likely to describe possible selves related to physical difficulties. Additionally, both patient groups report lower levels of self-efficacy in achieving their hoped for possible selves (as measured by beliefs that one is capable of achieving the possible selves) compared to the healthy control group. These findings were taken to demonstrate that having a chronic illness impacts on an individual's sense of self and is related to their possible selves. The authors further suggested the integration of the illness into possible selves to be a marker of adaptation although there was no measure of health related outcome to test this directly.

### **1.9.2 Possible selves and stressful life events**

Extending this research, Baretto and Frazier (2012) examined the degree to which salient life events became integrated into possible selves. The degree of integration was quantified by a coding system reflecting how much the content of each possible self was articulated in terms of the life event. A low degree of integration was defined as when the possible self and stressful event were in the same domain (e.g. having had a heart attack, a stressful event in the health domain, and a possible self, "to be fit", also in the health domain). The highest degree of integration was defined as where an event itself had become a possible self (e.g. experiencing a divorce and having a feared self "have my marriage end in divorce"). The study found that the more stressful a life event was perceived to be by an individual, the more it was integrated into their possible selves. Examples of such events were death of a parent and divorce.

The findings of this study further demonstrated that integration of such events into possible selves was related to motivation to achieve or avoid related outcomes, with higher levels of integration being associated with higher ratings of the self-regulatory processes of self-efficacy (beliefs about the ability to achieve or avoid the possible selves) and outcome expectancy (beliefs about the likelihood of achieving or avoiding the possible selves). The authors suggest that this may be important in terms of more adaptive coping behaviours in response to such events.

### **1.10 Interventions based on possible selves theory**

Based on the idea that possible selves are malleable and serve a function in regulating behaviour they have been incorporated into a number of interventions, with the aims of positively impacting behaviour and increasing motivation (e.g. Oyserman, et al., 2002). There is, as yet, no standardised way of delivering such interventions or consensus on what components they should include. They have most often been used in an educational context and been delivered in a group setting over a number of sessions. Sessions have tended to focus on guiding individuals to clarify and expand on both hoped for and feared possible selves, seeking to create a sense of “balance” between these. Following this, the focus is on teaching skills and strategies to help individuals achieve hoped for possible selves and avoid feared possible selves.

In the literature, the majority of such interventions have been targeted at student samples due to this being an important developmental period. Experiences at school may influence the development of positive and negative possible selves, which, in turn, impact on current behaviour and performance and future achievement (Oyserman & Fryberg, 2006). Targeting a possible selves intervention at such a population therefore has the potential to have an impact on students’ futures.



Two studies, Oyserman et al. (2002) and Oyserman et al. (2006) tested a possible selves intervention called, the “School-to-Jobs” (STJ) intervention, a brief, small group based intervention designed to enhance youths’ possible selves. Both found that the intervention resulted in number of positive outcomes related to school involvement (e.g. school grades), reporting small-medium effect sizes, and that such were mediated by changes in possible selves. Both studies also reported the intervention led to students having more “balanced” possible selves (Oyserman & Markus, 1990a). Oyserman et al. (2006) also included a standardised measure of depression finding a positive impact of the intervention on levels thereof.

The above studies suggest that interventions based on possible selves theory show some promise at being utilised as a framework of change. However, there appears to be a dearth of studies in the literature, despite many authors making statements about the use of possible selves based interventions based on findings of correlational studies (e.g. Norman, Windell, Lynch, & Manchanda, 2014). Additionally, there are no studies in clinical samples: if successes from educational contexts could be generalised to clinical settings with young people, possible selves interventions have the potential to limit the disruption to the developmental trajectory caused by the onset of mental illness.

### **1.11 Possible selves summary**

The discussion so far highlights the main areas of research regarding the concept of possible selves, that is, individuals’ hopes, fears and expectations for their future. Such research has demonstrated that possible selves are applicable to a wide range of populations and has suggested that they serve a function in wellbeing (Oyserman et al., 2004) and, where the main body of research has focussed, act as

self-goals that guide and motivate future behaviour (Oyserman & Markus, 1990b). The exact process by which possible selves influence behaviour, and under what circumstances, is still being debated: important points of consideration are that possible selves appear to have maximum motivational impact when hopes or expectations are “balanced” by a feared possible selves in the same domain (e.g. Ko et al., 2013) and when they are clearly elaborated and linked to strategies that move an individual towards or away from the possible selves (Oyserman et al., 2004). The relative importance of hoped for and feared possible selves in guiding behaviour appears to vary across studies but the reason for this remains unclear.

Research has also shown that possible selves are flexible and changeable over the lifespan and sensitive to developmental context (Cross & Markus, 1991), and possible selves also appear to be influenced by the occurrence of significant life events, including illness. It has been suggested that modifying such in response to events may be important in how individuals cope with and adjust to such events (Baretto & Frazier, 2012). Therefore, possible selves can be a useful tool in understanding sense of self and behaviour at transition points in the life cycle, such as adolescence/early adulthood and following the occurrence of life events.

More recently, a number of researchers have begun to incorporate the concept of possible selves into interventions designed to positively impact on behaviour and increase motivation (e.g. Oyserman et al. 2006). This area of research is still in its infancy but shows initial promise.

## **1.12 Possible selves and FEP**

### **1.12.1 Possible selves and objective recovery from FEP**

The above discussion highlights that negative symptoms are consistently related to poorer functional outcomes in FEP (Austin et al., 2013). Furthermore, there appears to be a bi-directional relationship whereby poor early functional recovery is related to chronic negative symptoms (Álvarez-Jiménez et al., 2012). This indicates that interventions targeting the formation and maintenance of negative symptoms and/or targeted at improving functioning are key for those suffering with FEP. To date, negative symptoms have demonstrated resistance to pharmacological interventions (Ventura et al., 2015) and the development of psychological interventions, such as the adapted CBT studies discussed above, is still in its infancy.

One component of negative symptoms is amotivation, and such motivational deficits have been independently linked to functional outcomes in FEP (Fervaha et al., 2015). As discussed previously, motivation is a key concept in possible selves theory: individuals' hopes, fears or expectations for their future have been consistently implicated in self-regulation, serving as self-goals that guide behaviour to move people towards or away from such goals (Oyserman et al., 2002). Although the exact self-regulatory processes involved in this are still being debated, research has found possible selves to exert maximal motivation impact when they are linked to plans and strategies to attain hopes or avoid fears (Oyserman et al., 2004) and when “balanced”, that is, when a hoped for or positively framed expected self is counterbalanced by a feared self in the same domain (Ko et al., 2013).

Findings highlight that motivational deficits are a particularly significant barrier to achieving recovery in FEP and that possible selves serve a function in motivating behaviour suggests. This suggests that the concept of possible selves may be applicable to FEP populations in potentially targeting negative symptoms and

promoting functional recovery. The above discussion additionally highlights that specifically adapted CBT shows some promise in improving negative symptoms and social functioning in FEP populations (e.g. Grant et al., 2012). The cognitive model of negative symptoms highlights defeatist and negative self-appraisals as important components in the development and maintenance of negative symptoms (Rector et al., 2005) and that targeting such improves motivation and leads to improvements in functioning. Furthermore, changes in positive beliefs about the self, have been associated with increased levels of activity in a FEP population (Hodgekins & Fowler, 2010). Negative and defeatist self-beliefs could be conceptualised in the possible selves framework as being less optimistic about future possible selves (e.g. believing that one is not very likely to achieve hoped for possible selves). Such beliefs mean individuals are less likely to engage in behaviours that move them towards hoped for and away from feared possible selves, i.e. they demonstrate lower levels of motivation (Hooker & Kaus, 1992). This further indicates that the concept of possible selves may have an application in FEP interventions.

It is important to understand more about the relationship between possible selves, negative symptoms and functioning in further understanding factors underpinning negative symptoms and thus future intervention development. To date there is only one published study of possible selves in FEP. Norman et al. (2014) examined the relationship between perceptions of current and future possible selves with self-esteem and symptomatology. Negative perceptions of possible selves were associated with more negative mood states and poorer self-esteem. This may indicate that perceptions of how one may be in the future can have a significant impact on self-esteem and negative mood states following FEP. This is likely to have a significant impact on recovery given that post-psychotic depression is linked with

poorer outcomes. Positive and negative symptoms were also assessed with the PANSS, with higher levels of both being associated with lower scores on incidences of current and future positive self but unrelated to current or future negative self. However, the study used predefined lists of possible selves, rather than allowing participants to describe their own hoped for and feared selves, limiting findings (Norman et al., 2014). Also, the study did not include a measure of functioning, considering the balance of possible selves and the data are cross-sectional. Further research examining links between symptomatology, functioning and possible selves in FEP is warranted.

#### **1.12.2 Possible selves and sense of self in FEP**

It is apparent that the impact of experiencing FEP on self-concept has the potential to disrupt the developmental trajectory at a crucial developmental stage in which career milestones and intimate relationships occur (McGorry & Yung, 2003). Furthermore, if an individual's sense of self becomes defined by the illness there is a risk of them leading a progressively more restricted life, become increasingly demoralised and have low self-esteem and depression (Lally, 1989). Such an impact on the developing sense of self has the potential to adversely influence long-term outcomes. Subjective models of recovery from FEP suggest that reparation of sense of self is an important part of the recovery process (Romano et al., 2010), alongside remaining hopeful, optimistic and alleviating symptoms, possibly more so negative symptoms, in order to aid social and vocational functioning.

As discussed, possible selves are sensitive to developmental context and stressful life events, including illness (Hooker, 1999). Considering the link between possible selves and behaviour, holding developmentally relevant possible selves may

be key in the completion of particular developmental tasks (Markus & Wurf, 1987). It has further been suggested that the sensitivity of possible selves to life events may be an important factor in how well individuals cope and adapt to such (Baretto & Frazier, 2012). There appears to be further potential to utilise possible selves based interventions to minimise potential disruption to developmental trajectory, aid in the reparation of self-concept and reduce the likelihood of engulfment. It is therefore important to explore the content of possible selves in those with FEP to further understanding the impact of FEP on the self-concept.

A pilot study with a FEP population found that a group intervention aimed at improving self-concept (with a primary focus on minimising engulfment effect of illness and recognising more positive future possibilities) found significant improvements in engulfment, symptoms (as measured by the PANSS) and quality of life. The same improvements were not seen in a control group who received treatment as usual (McCay et al., 2006). Whilst these results show some promise for interventions targeted at changing perceptions of self, it should be held in mind that they are limited by the small sample size, large numbers of drop-outs and the quasi-experimental design.

### **1.13 Summary and rationale for current research**

Developing effective interventions that promote recovery from FEP is crucial in preventing long-term disability. Research investigating the objective and subjective components of the recovery process in FEP has demonstrated that negative symptoms, psychosocial functioning and reshaping/reparation of sense of self are particularly important targets for intervention. Furthermore, considering sense of self, the onset of FEP occurs during a crucial developmental period and, as such, has the

capacity to have a significant impact of the developmental trajectory. This, coupled with the potential for an individual's developing sense of self to become defined by their "illness", has the potential to further impact recovery and longer-term outcomes.

Before targeted interventions can be developed, a better understanding of the impact of FEP on sense of self and on the factors underpinning negative symptoms is crucial. This thesis will apply the concept of possible selves to FEP to understand more about both of the above. Furthermore, the relatively novel application of possible selves theory to FEP will aid in the further development of possible selves theory. The current study will use a mixed methods design to address these aims.

First, this study will utilise a pre-existing dataset to understand more about the specific content of hoped for, expected and feared possible selves in individuals who have experienced FEP. Examining the different domains of possible selves generated by a sample of individuals with FEP and whether they make reference to mental health difficulties will aid understanding of how experiencing FEP may impact an individual's sense of self and views regarding their future.

This dataset will also be used to explore the relationship between aspects of possible selves and negative symptoms and functioning in those experiencing FEP. The above review highlights findings that having "balanced" possible selves is linked with higher levels of motivation, demonstrated by an increased likelihood of engaging in positive behaviour (Oyserman & Markus, 1990b). With regard to FEP, negative symptoms, but not positive symptoms, are consistently linked with poorer functional recovery in FEP. Furthermore, one component of negative symptoms, motivation, has been independently linked to functional outcomes in FEP (Fervaha et al., 2015). Considering this, it might be expected that the lower levels of motivation

demonstrated by a lack of balance between hoped for and feared possible selves may be reflected in increased negative symptoms, but not positive symptoms. Also, those with a lack of balance between hoped for and feared possible selves will also demonstrate poorer functioning.

Interventions based on cognitive models of negative symptoms have shown promise in improving such symptoms and functioning (e.g. Grant et al., 2012). These models highlight negative self-appraisals and defeatist beliefs, that prevent active engagement in meaningful activity, as important components in the development and maintenance of negative symptoms (Rector et al., 2005). Models of positive symptoms do not emphasise such beliefs (Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001). Furthermore, increased levels of activity in a FEP sample receiving ‘social recovery-orientated CBT’ (Fowler et al., 2009) were associated with changes in positive beliefs about the self (Hodgekins & Fowler, 2010). This highlights the impact that self-beliefs may have on functional outcomes. Within the possible selves framework, such beliefs may be conceptualised as being less optimistic about one’s future self. Individuals may then be less likely to engage in behaviours that move them towards hoped for possible selves and away from feared selves, i.e. they show lower levels of motivation. Accordingly, it would therefore be expected that those with less optimistic possible selves have higher levels of negative but not positive symptoms and demonstrate poorer functioning.

The current study will also utilise qualitative interviews with new participants to gain a deeper understanding regarding the impact of experiencing FEP on possible selves. More specific qualitative research questions will be informed by the quantitative findings.



## **1.14 Hypotheses and research questions**

Several specific research questions and hypotheses will be examined using quantitative analyses.

### **1.14.1 Descriptive research questions**

1. How do those who have experienced FEP describe their possible selves?
2. Do those who have experienced FEP refer to mental illness when describing their possible selves?

### **1.14.2 Hypotheses regarding relationships between possible selves, symptoms of psychosis and functioning**

1. Those with less optimistic possible selves will have higher levels of negative but not positive symptoms.
2. Those with a lack of balance between hoped for and feared possible selves will have higher levels of negative but not positive symptoms.
3. Those with less optimistic possible selves will demonstrate poorer functioning.
4. Those with a lack of balance between hoped for and feared possible selves will demonstrate poorer functioning.

### **1.14.3 Qualitative research question**

How does experiencing FEP impact possible selves?

## **2. Outline of the Research Design**

### **2.1 Overview**

This chapter provides an outline of the study methodology. The rationale for using a mixed methods approach, the specific design and paradigm chosen and the criteria utilised to ensure quality, will be described. The specific quantitative and qualitative elements of the study are discussed in detail in future chapters.

### **2.2 Defining mixed methods research**

A rapidly developing area of methodological choice, mixed methods research has recently been described as “a third methodological movement” (Tashakkori & Teddlie, 2010, p.804) and “...a research paradigm whose time has come” (Johnson & Onwuegbuzie, 2004, p.14). Despite this increase in popularity, reaching a consensus on a definition of mixed method research has proved complex: Johnson, Onwuegbuzie and Turner (2007) analysed 19 definitions of “mixed methods” given by researchers finding them to be diverse in terms of what was being mixed, when in the research process mixing was occurring and the amount and purpose of the mixing. A frequently cited and comprehensive definition of mixed methods and one used as the reference point in this study is offered by Creswell and Plano Clark,

Mixed methods research is a research design with philosophical assumptions as well as methods of inquiry. As a methodology, it involves philosophical assumptions that guide the direction of the collection and analysis of data and the mixture of qualitative and quantitative data in a single study or series of studies. Its central premise is that the use of quantitative and qualitative

approaches in combination provides a better understanding of research problems that either approach alone. (2007, p.5)

## **2.3 Methodological considerations**

### **2.3.1 Rationale for mixed methods**

A mixed methods design was chosen here because of the goal of expanding on initial quantitative results. Such results may yield important information about how those who have experience FEP describe their possible selves and give an insight into the relationship between possible selves and negative symptoms and functioning. However, a more detailed understanding of specific findings may be lacking. Furthermore, such data will only provide information about possible selves at one time point. Qualitative data will be used to build on this understanding by exploring specific findings in more detail to understand ‘how’ and ‘why’ they might have come about and provide more in-depth information about how possible selves may have changed over the course of FEP.

Additionally, combining quantitative and qualitative methods will provide a more comprehensive understanding of the topic of interest than would be achieved by using either method in isolation (Creswell & Plano Clark, 2007). This is of particular importance considering the dearth of previous research in this area.

### **2.3.2 Design**

An explanatory sequential design was employed as it best suited the research objectives and the fact that the study did not involve collection of any ‘new’ quantitative data. A convergent parallel design, where qualitative and quantitative

data are collected and analysed separately in the same phase, was also considered. However, with the lack of research in this area, it was thought that the structure of the explanatory sequential design would lead to a more informed and constructive qualitative element.

The explanatory sequential design involves two sequential phases with the first phase typically involving the analysis of quantitative data and the second phase utilising a qualitative methodology to follow up on specific quantitative results with the intention of elaborating on such (Ivankova, Creswell & Stick, 2006). In this study, phase one involved quantitative analysis of a pre-existing, cross sectional, anonymised data set. The data set contained information from those who have experienced FEP and included measures of symptom severity, functioning alongside possible selves data (section 3.3 provides further details). A subset of findings from this analysis were selected for further exploration and such aided construction of a topic guide for a semi-structured interview. This formed the basis of the qualitative phase, phase two, of the study. Interviews were conducted, audio-recorded, transcribed verbatim and analysed using Thematic Analysis (Braun & Clarke, 2008).

As recommended, a procedural diagram of the study is presented in Figure 1 to clarify the sequence of the research (Creswell & Plano Clark, 2007). Published guidelines were followed in the construction of such (Ivankova et al., 2006) including the use of the notation system first put forward by Morse (1991). This is now widely used in mixed methods research to aid discussion of design features, i.e. the uppercase “QUAL” and “QUAN” signifying that equal priority was given to each methodological component. Typically, priority is given to the quantitative aspect when using this design. However, considering that it is the qualitative aspect that involves the

collection of “new” data by the researcher and that possible selves have not been the focus of much research in those who have experienced FEP, both elements were treated equally.

### **2.3.3 Paradigm**

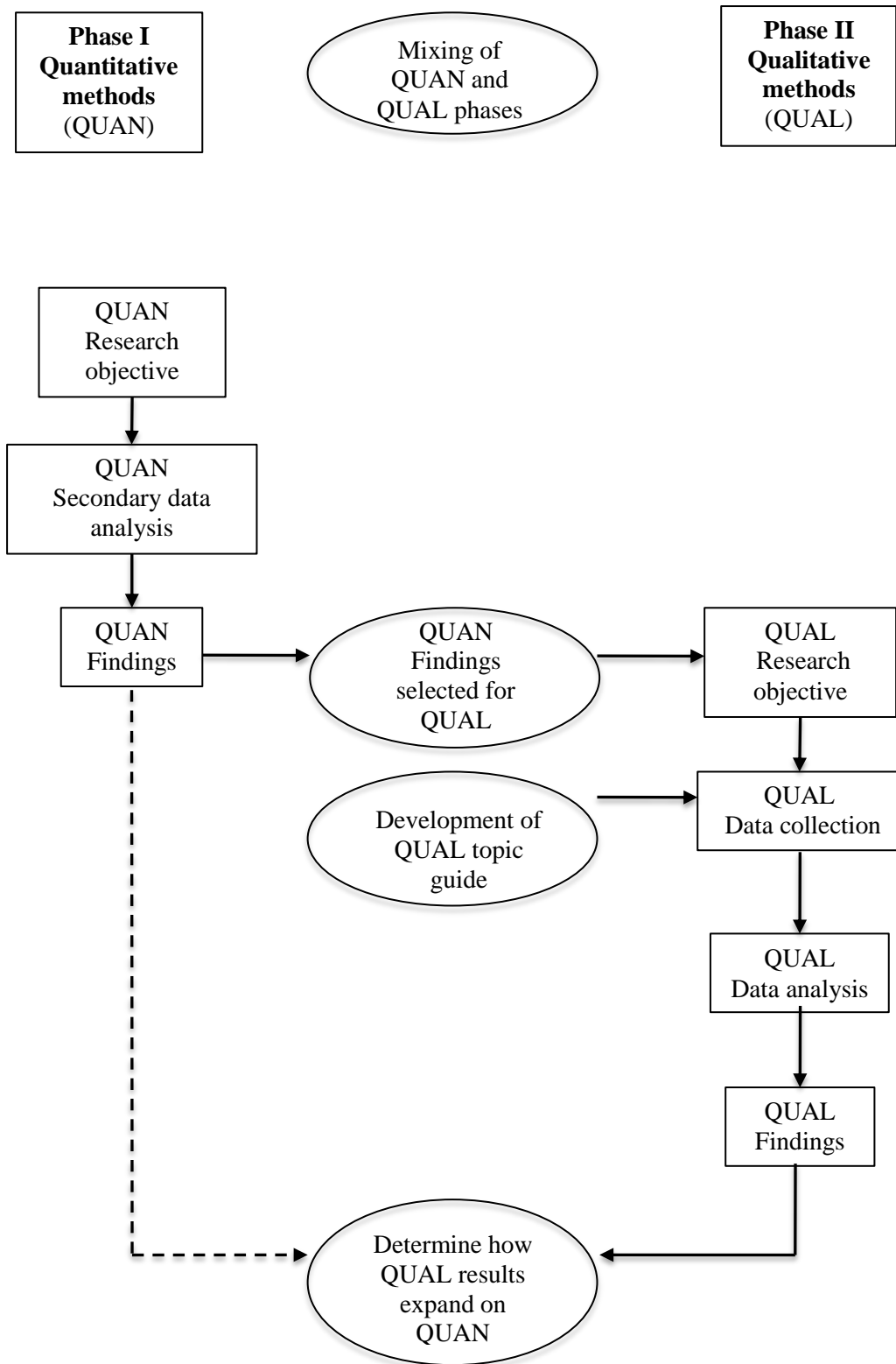
A fundamental challenge in mixed methods research is how to combine two research methods, quantitative and qualitative, that are underpinned by different paradigmatic assumptions: a fiercely debated topic in the literature that has seen mixed methods research placed against a backdrop of “paradigm wars”. Traditionally, quantitative methods are associated with a positivist paradigm whereas qualitative approaches are usually associated with an interpretive paradigm (Johnson & Onwuegbuzie, 2004; Yardley & Bishop, 2015).

Such differences, have sparked much debate about whether these paradigms can be integrated in mixed methods, with some seeing this as essentially incommensurable (Kuhn, 1970). However many researchers have now moved on to identifying a paradigm that provides a suitable philosophical framework for mixed methods research, that of pragmatism (Yardley & Bishop, 2015). The methodological pragmatists acknowledge the same paradigmatic assumptions as the purists but argue that researchers should use whatever methods are required to achieve optimum results, including ‘switching between’ different paradigms (Johnson & Onwuegbuzie, 2004). As such, this approach values both objective and subjective knowledge and supports the use of diverse methodologies on the basis of “what works” (Creswell & Plano Clark, 2011). Pragmatism places a greater emphasis on the research question, which is used to guide the choice of methodological and analytic techniques in light of their capacity to best address the research problem. Furthermore, a pragmatic

approach means attention does not need to be directed towards metaphysical concerns such as epistemology and ontology (Morgan, 2007). Pragmatism is now embraced by the majority of mixed methods researchers (Bishop, 2015).

This study was aligned with the assumptions of a pragmatic paradigm. The emphasis on abductive reasoning, intersubjectivity and transferability throughout the research process allowed for movement between, and successful integration of, the quantitative and qualitative elements of the study.

Reflective of the sequential nature of this study, a pluralistic pragmatic approach was adopted whereby different worldviews were taken for the different stages of the research (Creswell & Plano Clarke, 2007): a post-positivist position (assuming that there is one reality that can be known) was taken for phase one with a critical realist position being adopted for phase two. Critical realists assume that there is a reality “out there” that exists, independent of observers (Easton, 2010). However, whereas a naïve realist epistemology posits that this reality is easily accessed, a critical realist position is that reality is socially constructed and that how this reality is investigated is greatly influenced by social forces and our own experiences and assumptions (Willig, 2013). Chiefly, critical realists assume that “we can, and should, make attempts at investigating reality in itself, but do so cautiously and critically” (Pilgram & Bentall, 1999, p. 262). The aim of adopting different worldviews for each phase of the research was to produce more holistic and insightful results.



*Figure 1: Procedural diagram outlining the explanatory sequential design of this study*

### **2.3.4 Quality criteria**

In this study, divergent quality criteria- different criteria for the qualitative and quantitative components were used to demonstrate quality and are discussed in the relevant method chapters. This was thought to be an appropriate approach due to the distinct quantitative and qualitative phases of the design. This choice is also in line with findings by Bryman et al. (2008) where researchers showed a preference for utilising different criteria for the different components and is reflective of the lack of an agreed framework for assessing the quality of mixed methods research.

Alongside the use of specific criteria for demonstrating the quality of each component, the researcher addressed specific threats to validity when using the explanatory sequential design, as detailed by Creswell (2015). Such threats and how they have been addressed are detailed in Appendix A.

## **2.4 Structure of the write-up**

In line with the sequential design of this study, the quantitative and qualitative phases will be presented in separate consecutive chapters. Chapters 3, 4 and 5 will detail the quantitative method, results and discussion respectively. The qualitative method, results and discussion will be presented in chapters 6, 7 and 8 respectively. Chapter 9 will consider elements of the overall study.



### **3. Phase One: Quantitative method**

#### **3.1 Overview**

This section begins by introducing the pre-existing dataset utilised in this phase of the study. Further details of the dataset are then detailed along with the plan for analysing this.

#### **3.2 Quantitative data**

##### **3.2.1 Secondary data analysis**

The quantitative aspect of this study involved secondary data analysis, that is, “...analysis of data that was collected by someone else for another primary purpose” (p.920, Smith et al., 2011). A pre-existing dataset was made available to the researcher through the primary supervisor that included quantitative data relating to possible selves, functioning, psychotic symptoms and mood from individuals who had experienced FEP. Further details of the data set are outlined in the sections below.

#### **3.3 Dataset information**

##### **3.3.1 Recruitment**

Participants in the pre-existing data set were recruited as part of a research study examining outcomes and psychological mechanisms underpinning psychosis in patients accessing the Norfolk Early Intervention for Psychosis Service. Ethical approval was granted for this study in 2005.

All those accessing the Norfolk Early Intervention for Psychosis Service were approached about the study 3-6 months after entry into the service, by which time,

their acute episode of psychosis had often stabilised. Assessments were conducted as part of routine clinical assessments.

### **3.3.2 Sample size**

The pre-existing dataset included possible selves data from 80 clients aged between 15-36 in the Early Intervention for Psychosis Service in Norfolk.

G\* power was used to calculate the minimum effect size likely to be detected given the sample size of 80 (Faul, Erdfelder, Buchner & Lang, 2009). With a power of 0.80 and significance level 0.05, it is possible to detect an effect size of 0.27 for main correlation analyses in hypotheses 1 and 3 and 0.56 for the main analysis comparing the difference between two independent samples in hypotheses 2 and 4 (Appendix B). Compared to the one published study in this area (Norman et al, 2014), which found small to medium effect sizes, this seems adequate.

### **3.3.3 Consent**

At the time of the assessments, participants were asked to sign a consent form stating that they were agreeable to their data being used for research purposes. Data for any participant who did not wish their responses to be used for research purposes were not included in the study.

### **3.3.4 Confidentiality**

The data set was fully anonymised. Although verbatim quotes of participants' possible selves were included in the dataset, none of these are detailed or specific enough for participants to be identifiable.

### **3.4. Measures**

#### **3.4.1 Demographic information**

The dataset contained basic demographic information: age, gender and ethnicity. It also contained diagnostic information for each participant. Diagnoses for the sample were generated by the primary research team using the OPCRIT programme. OPCRIT has been used extensively to generate diagnoses, mainly for research purposes, and comprises of a checklist of symptoms for the main psychiatric classification systems and accompanying algorithms (McGuffin, Farmer, & Harvey, 1991). The OPCRIT system has been found to have good inter-rater reliability and convergent validity (agreement between OPCRIT and clinical diagnoses) (Brittain, Stahl, Rucker, Kawadler, & Schumann, 2013). This information was used to determine, based on previous research, if this sample of participants was representative of those within an Early Intervention in Psychosis service. This is important in assessing the generalisability of any findings.

#### **3.4.2 Possible Selves Interview**

Each client completed an open ended possible selves measure, based on the format outlined by Oyserman and Markus (1990b) (Appendix C). Clients generated three hoped for, three expected and three feared possible selves. Verbatim descriptions of these were recorded. For each possible self generated, participants were asked to rate on a Likert scale, “how much does this describe you now?”, “how much will this describe you in the future?” and “how much would you like this to describe you?” (0 = not at all to 4 = very much). The ratings for “how much will this describe you in the future?” for the three hoped for selves were summed to create an

“optimism” score, ranging from 0-12, that is, how optimistic is participants about becoming/achieving their hoped for possible selves overall. This measure of ‘optimism’ was novel to this study.

Using the verbatim descriptions of participants’ possible selves, the primary researchers coded the domain each encompassed from, personal development, possessions, interpersonal relations and emotional/physical wellbeing (see Appendix D for more information on how domains were defined). It was also noted whether participants’ made reference to mental illness in their possible selves. These domains were used to compute whether possible selves were “balanced” or “not balanced”. Possible selves were said to be “balanced” if 2 or 3 of a participants hoped for possible selves were balanced by feared possible selves in the same domain (e.g. if a participant has both a hope and fear relating to their career and both a hope and fear relating to relationships) and “not balanced” if only 0 or 1 hoped for possible selves was balanced by a feared possible selves are in the same domain.

When originally defined, having “balanced” possible selves was based on pairing positively framed expected possible selves, rather than hoped for possible selves, with feared possible selves (Oyserman & Markus, 1990b). However, this definition has not been rigidly adhered to in the literature with many defining and calculating “balance” by pairing hoped for and feared possible selves in the same domain (e.g. Frazier et al., 2000; Ko et al., 2013). Aloise-Young et al. (2001) found the same pattern of results when calculating balance using both of these methods. The pairing of hoped for, as opposed to positively framed expected selves, and feared selves was used as a measure of balance in this study to avoid excluding those who generated negatively framed expected possible selves.

### 3.4.3 Positive and Negative Syndrome Scale

Positive and negative symptoms of psychosis were assessed using The Positive and Negative Syndrome Scale (PANSS): a widely used measure in assessing symptoms in people with psychosis (Kay et al., 1987). The PANSS is a semi-structured interview which is typically administered by trained clinicians or researchers. Each of 30-items is rated on a 7-point (1–7) scale to evaluate patients' current severity level on each symptom (item). A rating of 7 on an item would denote the most severe level of psychopathology. The PANSS is divided into positive, negative and general psychopathology subscales, which have maximum scores of 49, 49 and 112 respectively (Kay et al., 1987). Only the positive and negative subscales were used in this study.

The PANSS has well established psychometric properties. Both the positive and negative subscales have been shown to have good inter-rater reliabilities of .72 and .80 respectively (Peralta & Cuesta, 1994). Furthermore, the positive subscale has been found to demonstrate moderate internal consistency (global  $\alpha=0.62$ ) with the negative subscale demonstrating very high internal consistency (global  $\alpha=0.92$ ) (Peralta & Cuesta, 1994).

It is acknowledged that, whilst the PANSS is frequently used as a measure of positive and negative symptoms, the Scale for the Assessment of Negative Symptoms (SANS) (Andreasen, 1989) has been recommended as a preferable measure of negative symptoms by the National Institute of Mental Health (Kirkpatrick et al., 2006). This is because the SANS consists of several separate subscales (i.e., affective flattening, alogia, avolition–apathy, anhedonia–asociality, and attention), improving the psychometric properties of the scale and allowing investigation of specific

components of negative symptoms. Whilst this would have been preferable in this study, the PANSS was the only measure of negative symptoms available in the pre-existing data set. This is still considered an acceptable measure of negative symptoms (Kirkpatrick et al., 2006).

#### **3.4.4 Beck Depression Inventory-II**

A measure of depression was included as a control variable as mood may influence beliefs about achieving possible selves and functioning. Depressive symptomatology was measured using the Beck Depression Inventory–II (BDI-II) (Beck, Steer, & Brown, 1996). The BDI-II is a 21-item self-report measure. Each item has four possible responses with scores for each item ranging from 0 to 3, depending on the symptoms presence and severity over the preceding two weeks. The total scores range from 0 to 63 with scores 29 or over demonstrating severe depression (Beck, Steer, & Brown, 1996). The BDI-II has been found to show good internal consistency (0.9) and test-retest reliability (ranging from 0.73 to 0.96) (Wang & Gorenstein, 2013).

#### **3.4.5 Heinrichs Quality of Life Scale**

The Heinrichs Quality of Life Scale (QLS) (Heinrichs, Hanlon, & Carpenter, 1984) is a 21 item semi-structure interview designed to assess quality of life in those with schizophrenia. It should be administered by a trained clinician or researcher and takes approximately 45 minutes to complete. The 21 items are scored in a 7 point-scale where higher ratings correspond to a higher level of satisfaction. Each item maps onto one of four subscales; interpersonal relations; instrumental role; intrapsychic foundations, and common objects and activities. These scales aim to

represent the key expressions of the deficit syndrome on schizophrenia (Simon-Abbadì, Guelfi, & Ginestet, 1999). Browne et al. (2000) argued that the QLS was an adequate measure of social functioning. For this study, the total QLS score was used as a board measure of social functioning, as in other studies with FEP populations (e.g. Addington, Saeed & Addington, 2005).

The original developers reported the QLS to have acceptable psychometric properties with reliability for categories ranging from .92 to .98 and good inter-rater reliability, of .9 on the total score (Heinrichs et al., 1984). The QLS also demonstrates significant convergent validity with the Lehman Quality of Life Interview, another commonly used measure of quality of life in those with severe mental health difficulties (Lehman, Postrado, & Rachuba, 1993).

### **3.5 Plan for data analysis**

Before analysis, the data were checked for obvious inputting errors. Levels of missing data were also calculated.

#### **3.5.1 Descriptive research questions**

To investigate the descriptive research questions (“how do people who have experienced FEP describe their possible selves?” and “Do individuals who have experienced FEP refer to mental illness when describing their possible selves?”) the verbatim descriptions of hoped for, expected and feared possible selves in the dataset were used to identify the frequencies of possible selves listed in each of the four categories: possessions, emotional/physical wellbeing, interpersonal relations and personal development. These descriptions were also used to calculate the percentage

of individuals who mentioned their mental health within their hoped for, expected and feared possible selves.

Additional analyses were carried out to further explore differences in how participants described their hoped for and feared possible selves. For each possible self generated, participants were asked to rate on a Likert scale, “How much does this describe you now?”, “How much will this describe you in the future?” and “How much would you like this to describe you?” (0 = not at all to 4 = very much). The ratings for each of these for the 3 hoped for and 3 feared possible selves for each participant were summed to create total scores. Any discrepancies between hoped for total scores and feared total scores for each questions were investigated further using Wilcoxon-Signed rank tests.

These additional analyses did not include data for expected possible selves due to the difficulty in interpreting findings because of the mix of positive and negatively framed possible selves.

### **3.5.2 Hypothesis one: those with less optimistic possible selves will have higher levels of negative but not positive symptoms**

This hypothesis was explored with a Spearman’s Rank Correlations between “optimism scores”, calculated from the possible selves interview, and negative and positive psychotic symptoms, as assessed by the negative and positive sub-scales of the PANSS. Non-parametric correlations were used given that none of the measures were normally distributed and could not be transformed to meet parametric assumptions.



**3.5.3 Hypothesis two: those with a lack of balance between hoped for and feared possible selves will have higher levels of negative but not positive symptoms.**

A Mann-Whitney U test was used to consider whether there were significant differences in negative symptoms, as assessed by the negative subscale of the PANSS, between those with “balanced” or “not balanced” hoped for and feared possible selves. “Balance” was calculated using data from the possible selves interview. The same analysis was then conducted to explore if there were significant difference in positive symptoms, as assessed by the positive subscale of the PANSS, between those with “balanced” and “not balanced” possible selves. Non-parametric, Mann-Whitney U tests were utilised in both analyses because positive and negative symptoms were not normally distributed for those with “balanced” and “not balanced” possible selves.

**3.5.4 Hypothesis three: those with less optimistic possible selves will demonstrate poorer functioning**

In order to explore this hypothesis, a non-parametric Spearman’s Rank Correlation was carried out between total score on the QLS, used as a measure of functioning, and “optimism” scores derived from the possible selves interview. A non-parametric Spearman’s correlation was carried out as optimism scores were not normally distributed. To further explore this relationship, a partial correlation was carried out between the above variables whilst controlling for depression.

**3.5.5 Hypothesis four: those with a lack of balance between hoped for and feared possible selves will demonstrate poorer functioning**

An independent samples t-test was carried out to explore differences in functioning between those with “balanced” and “not balanced” hoped for and feared possible selves. Total QLS scores were used as a measure of functioning.

## **4. Phase One: Quantitative Results**

### **4.1 Overview**

This section begins with an explanation regarding missing data and a description of the procedures utilised, prior to data analysis, in the testing of statistical assumptions. This is followed by a description of the research sample and an overview of the main study measures, including a discussion of differences within the population and between this sample and previous research samples. Each research question and hypothesis is then considered in turn followed by a summary of all the findings from the dataset.

### **4.2 Data screening and assumption testing**

#### **4.2.1 Missing data**

On screening the existing dataset for missing data, it became apparent that there was variation in how many of the three hoped for, three expected and three feared possible selves participants had been able to generate in the possible selves interview. Data were also not complete for another main study measure, the Heinrichs Quality of Life Scale (QLS). Consequently, not all the participants in the dataset could be included in all of the analyses and pairwise deletion was used. Every effort was made to retain as much data as possible at each stage of the analysis. A description of the data available for each research question and hypothesis is given as each are considered.

#### **4.2.2 Assumption testing**

Assumption testing is detailed for each hypothesis due to the different number of participants included in each analysis. If variables were found not to be normally distributed any outliers were first removed to ascertain if this rectified the issue. If this was not successful, square root data transformations were applied. For all analyses where this process was necessary, it did not result in normally distributed variables and as such non-parametric statistics were used.

### **4.3 Descriptive data**

#### **4.3.1 Description of the research sample**

In total, 80 participants took part in the possible selves interview and were included in the dataset. The demographic characteristics and diagnoses of such participants are summarised in Table 1.

Table 1

*Summary Data for Demographic Variables and Diagnoses (n=80)*

	<b>N</b>	<b>%</b>	<b>M</b>	<b>SD</b>	<b>Range</b>
<b>Age (years) and Gender</b>					
Full sample			22.33	4.69	15-36
Female	24	30	20.83	4.41	15-30
Male	56	70	22.96	4.70	17-36
<b>Ethnicity</b>					
British	75	93.80			
Other white background	2	2.50			
African	2	2.50			
Prefer not to say	1	1.30			
<b>Primary DSM diagnosis (OPCRIT)</b>					
Schizophrenia	21	26.30			
Schizophreniform disorder	8	10.09			
Depression with psychosis	7	8.80			
Atypical psychosis	12	15.00			
Probable schizoaffective/depressed or depression with psychosis	7	8.80			
Bipolar with psychosis	14	17.50			
Bp disorder	1	1.30			
Mania with psychosis	2	2.50			
Major depression	1	1.30			
Delusional Disorder	6	7.50			
Schizoaffective mania	1	1.30			

The gender difference in the current study is in line with other studies where the incidence of FEP has been found to be higher in men than in women (Kirkbride et al., 2006; Ochoa, Usall, Cobo, Labad, & Kulkarni, 2012). An epidemiological study

of first episode psychosis in East Anglia found a comparable gender split to that observed here: over the first 18 months of data collection 66.2% of individuals entering Early Intervention Services were male and 34.8% were female (Kirkbride, Stubbins & Jones, 2012).

Participants in this sample ranged in age from 15 to 36 years old. This is line with the fact that Early Intervention in Psychosis Services, from which the sample were recruited, are commissioned to work with those aged between 14-35 (Department of Health, 2001). The mean age of the 56 men who took part in the research is higher than the mean age of the 24 women however this difference is not significant ( $U = 492$ ,  $z = -1.90$ ,  $p = .057$ , two-tailed). Other research in this population has consistently found a later age of onset of psychosis among females compared to males (Thorup et al., 2014). However, in entire adult onset samples, data may be skewed by a secondary peak of psychosis close to the time of the menopause in females (Kirkbride et al., 2012). When only considering an early intervention sample, Kirkbride et al. (2012) found age of onset to be similar for both males and females.

The sample recruited lacked ethnic diversity with the majority of participants describing themselves as White British. This is in line with data from the Office for National Statistics for the East of England area, estimating that 88% of the population is made up of people describing themselves as White British (Corke & Wood, 2009). It should be noted, however, that in samples from more ethnically diverse areas the incidence of first episode psychosis has been found to be significantly higher in a number of black and minority ethnic groups (Kirkbride et al., 2008).

As generated by the OPCRIT programme, the sample recruited demonstrated a range of non-affective and affective psychoses with 11 different diagnoses being

recorded in total. The most common diagnosis was schizophrenia followed by bipolar with psychosis. The heterogeneity in diagnoses may reflect the difficulties in making diagnostic decisions in first presentation psychosis (Coentre, Blanco, Fontes, & Power, 2011) with some recommending that only a generic diagnosis of ‘psychosis’ be given at this stage (McGorry, Killackey, & Yung, 2008).

#### **4.3.2 Description of the study measures**

A summary of data for each study measure is shown in Table 2 and described in the relevant sections below.

Table 2

*Summary Data for Study Measures*

Measure	M	Median	SD	Range	Skewness	SE of Skewness	Kurtosis	SE of Kurtosis
<b>PANSS Negative scale (n=80)</b>	13.34	12.00	5.54	7-31	1.01***	.27	.76	.53
<b>PANSS Positive scale (n=80)</b>	12.90	12.00	5.02	7-28	.80**	.27	.19	.53
<b>QLS Total (n=65)</b>	75.37	75.30	23.97	25-124	-.13	.30	-.53	.59
<b>Optimism (n=74)</b>	7.76	8.00	3.35	0-12	-.59*	.28	-.44	.55
<b>BDI-II Total (n=80)</b>	20.69	21.50	13.54	0-61	.32	.27	-.28	.53

\*significantly skewed variable at  $p < .05$  (skewness/SE skewness  $> 1.96$ )

\*\* significantly skewed variable at  $p < .01$  (skewness/SE skewness  $> 2.58$ )

\*\*\* significantly skewed variable at  $p < .001$  (skewness/SE skewness  $> 3.29$ )

**4.3.2.1 Positive and negative symptoms**

Mean scores on the positive subscale of the PANSS indicate that the level of positive symptoms here is similar to other first episode psychosis samples 6 -12 months after being accepted into an Early Intervention in Psychosis Service (e.g. Addington, Leriger, & Addington, 2003). However, negative symptoms appear to be somewhat lower than in other comparable samples (e.g. Addington & Addington, 2009).

The mean PANSS positive scale score indicates that the majority of participants had low levels of positive symptoms (Kay et al., 1987) and indeed this subscale showed a significant positive skew. It should be noted that on converting scores on this subscale into percentile ranks, as outlined in the PANSS manual (Kay



et al., 1987), four participants scored above the 75<sup>th</sup> percentile, categorising their scores as “high” or “very high”(Kay et al., 1987).

Similarly, converting the scores on the negative subscales to percentile ranks revealed that three participants scored above the 75<sup>th</sup> percentile, again categorising such scores as “high” or “very high” (Kay et al., 1987). However, the majority of participants had low levels of negative symptoms, demonstrated by the significant positive skew of this subscale.

#### ***4.3.2.2 Optimism***

Optimism scores ranged from 0-12 but were significantly negatively skewed with more participants scoring at the higher end.

#### ***4.3.2.3 Quality of life***

Participants mean total scores on the QLS, 6-12 months after being accepted into the Early Intervention Service were compared to a large sample in a similar population. In that sample, the mean score on the QLS after 12 months with the service was 63.83 (SD = 20.0). This increased to 74.05 (SD = 21.2) after 3 years (Addington & Addington, 2009). Hence, the participants here scored higher, indicating better overall functioning. This may be due to the lower levels of negative symptoms in this sample compared to others.

#### ***4.3.2.4 Depression (control variable)***

The mean score on the BDI-II would indicate moderate levels of depressions in the sample. This is similar to other comparable samples (Birchwood et al., 2000).

### **4.3.3 Summary of descriptive data**

Considering demographic variables, the sample of participants in the dataset is comparable to other early intervention in FEP samples from the region. However, due to a lack of ethnic diversity the sample is not comparable to samples recruited from other areas in the UK. The sample shows heterogeneity in terms of diagnoses but this is not unusual in early psychosis samples.

In terms of the main study measures, this sample appears to have lower levels of negative symptoms and better levels of functioning than other FEP samples. However, levels of positive symptoms and depression are in line with other comparable samples.

## **4.4 Descriptive research questions**

### **4.4.1 How do people who have experienced FEP describe their possible selves?**

The verbatim descriptions of hoped for, expected and feared possible selves were coded into four domains: possessions, personal development, interpersonal relations or emotional/physical wellbeing. A summary of the number of hoped for, expected and feared possible selves in each domain is shown below in Table 3. Each of the 80 participants was asked to generate three hoped for, three expected and three feared possible selves and, as such, there are a total of 240 possible selves for each of these.

Table 3

*Summary of Domains of Hoped for, Expected and Feared Possible Selves*

	Hoped for possible selves		Feared possible selves		Expected possible selves	
	n	%	n	%	n	%
<b>Personal development</b>	98	40.83	37	15.42	87	36.25
<b>Possessions</b>	45	18.75	33	13.75	29	12.10
<b>Emotional/ physical well being</b>	27	11.25	78	32.5	44	18.33
<b>Interpersonal relations</b>	62	25.83	64	26.67	55	22.92
<b>Missing</b>	8	3.33	24	10	25	10.42
<b>No category available</b>	0	0	4	1.67	0	0
<b>Total</b>	240	100	240	100	240	100

***4.4.1.1 Hoped for possible selves***

Regarding missing data for the hoped for possible selves, eight (3.33%) responses were missing. Closer inspection of the data revealed that only 74 of the 80 participants generated the three hoped for possible selves requested in the possible selves interview.

It was striking that the vast majority of hoped for possible selves generated appeared to be very realistic, achievable and age appropriate goals rather than being based on idealistic or unlikely outcomes. The most listed domain of hoped for possible selves was “personal development” with 98 (40.83%) of all hoped for

possible selves generated being categorised in this way. Such hoped for possible selves in the dataset tended to relate to specific career goals, such as, “being a musician”, “becoming a nurse”, “do a masters in social work” or were related to more general career development “graduate from uni” and “get a good job”.

“Interpersonal relations” was the second most listed category of hoped for possible selves with a total of 62 (25.83%) possible selves being in this category. Specific examples of such were, “develop more of a social life”, “have a child”, “close to all mates again”, “to meet a partner” and “have own independence”.

For the “possessions” category, the majority of hoped for possible selves related to owning property and a car. This was the third most mentioned category with 45 (18.75%) hoped for possible selves. Finally, hoped for possible selves in the category “emotional/physical wellbeing” were listed fewer than any other category with 27 (11.25%) hoped for possible selves categorised in this way. Possible selves about general wellbeing, such as, “happiness in the future”, “get confidence back” and “be more active” were listed alongside possible selves more specific to the experience of psychosis, “be without voices”. It is perhaps surprising that this is the least mentioned category considering the common experience of a recent episode of psychosis and context of the data collection, i.e. within a specialist mental health service.

#### ***4.4.1.2 Feared possible selves***

The possible selves interview required participants to generate three feared possible selves but 10% of the responses were missing. Scrutiny of the data set revealed that only 65 of the 80 participants were able to list three feared possible

selves. Furthermore, three of the 80 participants who took part in the interview and who were able to generate hoped for possible selves were not able to list any feared possible selves.

For feared possible selves, more were categorised as relating to “emotional/physical wellbeing” than any other category. Seventy-eight (32.50%) of all feared possible selves were in this domain and included many references to specific fears as a result of experiences of psychosis/mental distress “things not working out with EIS”, “still be affected by the past (mentally)”, “living in a mental hospital” and “continuing to have low confidence and nerves”.

The second most listed domain of feared possible selves was “interpersonal relations” with 64 (26.67%) feared possible selves categorised as relating to such. In selecting examples of such from the data it appeared that some fears in this area were related to specific traumatic experiences, such as, “being attacked”, “reliving abuse” and “boyfriend still beats me up”. Such experiences may have played a role in the onset of psychosis (Beards et al., 2013). There were also a number of feared possible selves in this category that generally related to the idea of being isolated and alone.

Feared possible selves in the “personal development” and “possessions” categories were listed a similar number of times with 37 (15.42%) and 33 (13.75%) of feared possible selves being categorised as such respectively. A number of feared possible selves in the “personal development” category related to a lack of independence (e.g. “stay at home too long”, “stuck at home with parents”, “unable to drive/no independence”). Others related to a lack of career progression, “not getting into college” and “having no job/unemployable” with more than one participant mentioning “prison” as a feared possible self in this area. In the “possessions”

category, money and housing appeared to be the two main themes of feared possible selves, e.g. “being homeless”, getting kicked out of home”, “money problems” and “not being able to pay rent”.

There were four (1.67%) feared possible selves that could not be categorised in the aforementioned categories, such as, “effects of global warming/radiation” and “natural disasters”.

#### ***4.4.1.3 Expected possible selves***

As with hoped for and feared possible selves, participants were each asked to generate three expected possible selves but 10.25% of these data were found to be missing. Four participants were not able to list any expected possible selves with 66 out of the 80 generating the complete compliment of three expected possible selves.

The additional consideration with expected possible selves over hoped and feared possible selves is whether they are positively or negatively framed, i.e. are they more akin to a hope or a fear. Of the 215 generated expected possible selves, 176 (81.9%) were coded as being positively framed with 39 (18.1%) being negatively framed. This would suggest participants have expectations in terms of possible selves that are relatively optimistic. Some examples of negatively framed expected possible selves are; “..end up in prison”; “drinking and gambling” and “lonely and isolated” with more positive expected possible selves being; “some element of success at work”; “exciting year abroad” and “get married”.

The most frequently reported category of expected possible selves was “personal development” with 87 (36.25%) responses being classified in this way. In this category participants listed expected possible selves related to their career e.g. “get a

vocational qualification”, “study music”, “have own business” and “not achieving in terms of music” as well as other developmental goals and aims including, “move out of home”, “be driving” and “go travelling”. “Interpersonal relations” and “emotional and physical wellbeing” were the next most generated categories with 55 (22.92%) and 44 (18.33%) of expected possible selves in each of these categories respectively. “Be a father”, “being isolated”, “have a good social life and “not having many friends” typify the responses in the interpersonal relations category whilst examples from the emotional and physical wellbeing category were “liver/kidney disease or cancer”, “be more active and “be confident again”. The least mentioned category of expected possible selves was “possessions” with 29 (12.10%) responses. The majority of responses here related to having a car and/or a house.

#### ***4.4.1.5 Additional analyses***

Following the finding of differences in how participants described their hoped for and feared possible selves, other possible differences were investigated. For each possible self generated, participants were asked to rate on a Likert scale, “How much does this describe you now?”, “How much will this describe you in the future?” and “How much would you like this to describe you?” (0 = not at all to 4 = very much). The ratings for each of these for the three hoped for and three feared possible selves for each participant were summed to create total scores. These are summarised in Table 4: “How much would you like this to describe you?” for feared possible selves is not included as only one participant rated anything but 0 for this.

These data were not explored for expected possible selves due to the difficulty in interpreting findings because of the mix of positive and negatively framed possible selves.

As to what participants thought best described them now, overall participants rated their feared possible selves as more accurate descriptions of themselves now as opposed to their hoped for possible selves. However, this difference was not significant ( $Z = 1.79$ ,  $p = .073$ , two-tailed).

There was an interesting discrepancy between how much participants would like their hoped for possible selves to describe them and how much they believe that this will describe them with higher ratings given for the former. This difference was significant,  $Z = -5.90$ ,  $p < .001$ , two-tailed, indicating a discrepancy between hopes and beliefs.



Table 4

*Summary Data for Total Scores for Follow Up Questions*

	<b>M</b>	<b>Median</b>	<b>SD</b>	<b>Skewness</b>	<b>SE of skewness</b>	<b>Range</b>
<b>Hoped for possible selves</b>						
“How much does this describe you now?”	3.32	3.00	3.03	1.05***	.31	0-12
“How much will this describe you in the future?”	7.76	8.00	3.35	-.67*	.31	0-12
“How much would like this to describe you?”	11.1	12.00	1.65	-2.10***	.31	5-12
<b>Feared possible selves</b>						
“How much does this describe you now?”	4.58	4.00	3.54	.47	.31	0-12
“How much will this describe you in the future?”	3.89	3.00	2.59	1.31***	.31	0-12

\*significantly skewed variable at  $p < .05$  (skewness/SE skewness  $> 1.96$ )

\*\* significantly skewed variable at  $p < .01$  (skewness/SE skewness  $> 2.58$ )

\*\*\* significantly skewed variable at  $p < .001$  (skewness/SE skewness  $> 3.29$ )

#### **4.4.2 Do individuals who have experienced FEP refer to mental illness when describing their possible selves?**

##### ***4.4.2.1 Hoped for possible selves***

All 80 participants in the data set described at least one hoped for possible self. Of those, nine participants (11.3%) made reference to their mental health in their hoped for descriptions, for example, “Be without voices” or “Being well- not on medication for voices and not needing support”. Of these nine participants, eight mentioned mental health problems in only one hoped for possible selves with one

participant making reference to such in two hoped for possible selves. Seven of these nine participants made reference their mental health in the first hoped for possible selves that they listed. This might suggest that this is particularly salient for these participants.

#### ***4.4.2.2 Feared possible selves***

Seventy-seven participants described at least one feared possible self. Of these, 34 (44.2%) people generated one feared possible self that made reference to mental health problems. A further two participants (2.6%) listed two feared selves that made reference to fears with one participant mentioning mental health problems in all three feared possible selves listed. Twenty-one of the 41 (51.2%) total references to mental health problems in feared possible selves were made in the first feared self generated, eight out of 41 (19.5%) were in the second feared self whilst 12 out of 41 (29.3%) were in the third feared possible self listed.

#### ***4.4.2.3 Expected possible selves***

Of the 80 participants, 76 described at least one expected possible selves. In total, there were 13 references to mental health problems in expected possible selves: 10 participants (13.2%) made one reference and three participants (4.0%) made two references. As with such references in hoped for and feared possible selves, the majority of references were made in the first expected possible selves listed, eight out of the 13 references (61.5%). Also of note is that there was a relatively even split between positive and negative references to mental health in the expected possible selves: seven of the 13 references to mental health had a negative outlook (e.g. “end up taking too many paracetamol”, “expect voices and flashbacks to continue” and

“suicide”) with eight of the 13 references being more positive (e.g. “be more mentally well”, “continue getting better” and “delusions will leave”).

## **4.5 Hypothesis testing**

### **4.5.1 Optimism and negative symptoms (hypothesis one)**

It was predicted that those with less optimistic hoped for possible selves would have higher levels of negative but not positive symptoms. This relationship was explored using the positive and negative subscales from the PANSS and the calculated optimism scores. Optimism scores were calculated as follows: participants were asked to rate on a 4-point Likert scale “how much will this describe you in the future” for each hoped for possible selves they described. These ratings were summed to create an optimism score, ranging from 0 (not at all optimistic) to 12 (very optimistic). In order to calculate optimism, participants needed to have generated and rated three hoped for possible selves. Seventy-four of the total 80 participants had done so and were included in this analysis.

The total scores for PANSS negative subscale and positive subscale were not normally distributed: they both showed a significant positive skew with more participants scoring at the lower end of the scale. The optimism scores were also not normally distributed showing a significant negative skew, with more participants scoring at the higher end (Table 5). Such deviations from normality were supported by visual inspection of the data and Kolmogorov-Smirnov tests,  $D(74) = .147, p < .001$  and  $D(74) = .143, p = .001$  for the PANSS negative and PANSS positive subscales respectively and  $D(74) = .123, p = .007$  for optimism scores. Therefore non-parametric Spearman’s Rank Correlations were performed.

Table 5

*Summary Data for PANSS Negative and Positive Subscales and Optimism Scores*  
( $n=74$ )

Measure	M	Median	SD	Skewness	SE of Skewness	Kurtosis	SE of Kurtosis	Range
PANSS Negative scale	12.78	12.00	4.72	.73 **	.28	-.25	.55	7-25
PANSS Positive scale	12.78	12.00	4.94	.85**	.28	.45	.55	7-28
Optimism	7.76	8.00	3.35	-.59*	.28	-.44	.55	0-12

\*significantly skewed variable at  $p < .05$  (skewness/SE skewness  $> 1.96$ )

\*\* significantly skewed variable at  $p < .01$  (skewness/SE skewness  $> 2.58$ )

No significant association was found between negative symptoms and optimism ( $r_s = -.19$ ,  $p = .057$ , one-tailed,  $n = 74$ ). This is at odds with what was predicted. It is possible that there is an association but with the small effect size of .19, the study is underpowered to detect such. Prior to the analyses calculations using G\* power (Faul et al., 2009) revealed that, with a sample size of 80, a power of 0.80 and significance level 0.05, it would be possible to detect a minimum effect size of 0.27 for the above analysis (Appendix B). This is larger than the effect size here.

As predicted there was no significant association between positive symptoms and optimism ( $r_s = .03$ ,  $p = 0.39$ , one-tailed,  $n = 74$ ).

#### **4.5.2 Balance and negative symptoms (hypothesis two)**

It was hypothesised that those with a lack of “balance” between hoped for and feared possible selves would have higher levels of negative but not positive

symptoms. “Balance” was calculated by comparing the domains encompassed by participants’ hoped for and feared possible selves. If two or three hoped for and feared possible selves were in the same domain then the possible selves were said to be “balanced” whereas if only one or none of an individuals hoped for and feared possible selves were in the same domain then the possible selves were said to be “not balanced”. As such, “balance” could only be calculated for those participants who generated three hoped for and three feared possible selves. Sixty-four of the 80 participants generated such. However a further three participants reported possible selves that could not be categorised into the specified domain (e.g. fearing global warming) and so 61 participants were included in the analysis. Table 6 shows the frequency of participants with “balance” and “not balanced” possible selves.

Table 6

*Frequency of Participants with “Not Balanced” and “Balanced” Possible Selves*  
(*n*=61)

	Frequency	Percent (%)
<b>Not balanced</b>	34	55.7
<b>Balanced</b>	27	44.3

Table 7

*Summary Data for PANSS Positive and Negative Subscales for those with “Not Balanced” (n=34) and “Balanced” (n=27) Possible Selves*

	M	Median	SD	Skewness	SE of Skewness	Kurtosis	SE of Kurtosis	Range
<b>PANSS negative subscale</b>								
<b>Not balanced</b>	12.06	11.00	4.75	1.04 **	.40	.51	.79	7-24
<b>Balanced</b>	12.70	12.00	4.44	1.10*	.45	.95	.87	7-25
<b>PANSS positive subscale</b>								
<b>Not balanced</b>	11.85	10.00	4.57	1.45***	.40	3.05	.79	7-28
<b>Balanced</b>	13.56	13.00	5.30	.57	.45	-.058	.87	7-27

\*significantly skewed variable at  $p < .05$  (skewness/SE skewness  $> 1.96$ )

\*\* significantly skewed variable at  $p < .01$  (skewness/SE skewness  $> 2.58$ )

\*\*\* significantly skewed variable at  $p < .001$  (skewness/SE skewness  $> 3.29$ )

The PANSS negative subscale was significantly positively skewed, with more participants scoring at the lower end, for both those with “balanced” and “not balanced” possible selves. Kolmogorov-Smirnov tests further supported that this subscale was not normally distributed for those with balanced possible selves ( $D(27) = .23, p = .001$ ). The PANSS positive subscale was significant positively skewed for those with “not balance” possible selves. This deviation from a normal distribution is supported by a Kolmogorov-Smirnov test ( $D(34) = .22, p < .001$ ). As such, non-parametric Mann-Whitney U tests were carried out to explore difference in negative and positive symptoms between those with balanced and not balanced possible selves.

No significant difference in negative symptoms was found between those with “balanced” and “not balanced” possible selves ( $U = 402$ ,  $z = -.83$ ,  $p = .21$ ,  $r = -.11$ , one tailed). This is at odds with what was predicted. There was also no significant difference in positive symptoms between those with balanced and not balanced possible selves ( $U = 385$ ,  $z = -1.08$ ,  $p = .14$ ,  $r = -.11$ , one tailed).

#### 4.5.3 Optimism and functioning (hypothesis three)

It was hypothesised that those with less optimistic possible selves would demonstrate poorer functioning. This was explored using the optimism scores and total scores on the Heinrichs Quality of Life Scale (QLS). When the data were scrutinised for missing data, 59 of the total 80 participants had completed the QLS and generated three hoped for possible selves (needed to calculate an optimism score).

Table 8

*Summary Data for Optimism and QLS Total Scores (n=59)*

Measure	M	Median	SD	Skewness	SE of Skewness	Kurtosis	SE of Kurtosis	Range
<b>Optimism</b>	7.80	8.00	3.34	-.61 *	.31	-.32	.61	0-12
<b>QLS</b>	77.05	75.70	22.01	-.01	.31	-.35	.61	28.7-124.00

\*significantly skewed variable at  $p < .05$  (skewness/SE skewness > 1.96)

The QLS scores showed no significant skew and a Kolmogorov-Smirnov test further supported that they were normally distributed ( $D(59) = .059$ ,  $p = .20$ ). However, the optimism scores for this sub-set of participants were not normally

distributed showing a significant negative skew, with more participants scoring at the higher end. This was supported by visual inspection of the data and a Kolmogorov-Smirnov test ( $D(59) = .12, p = .039$ ). As such, a non-parametric correlation (Spearman's Rank) was carried out. This revealed a significant positive correlation between optimism and functioning ( $r_s = .36, p = .002$ , one-tailed,  $n = 59$ ). This finding is in agreement with what was predicted: that those who are more optimistic about achieving their hoped for possible selves show better functioning.

QLS scores were significantly negatively correlated with scores on the BDI-II ( $r_s = -.38, p = .003$ , two-tailed,  $n = 59$ ). As such, a partial non-parametric correlation (Spearman's Rank) was carried out between QLS scores and optimism to control for the effects of depression. As hypothesised, the relationship between functioning and optimism remained after controlling for depressive symptoms ( $r_s = .33, p = .006$ , one-tailed,  $n = 56$ ).

#### **4.5.4 Balance and functioning (hypothesis four)**

It was further hypothesised that those with a lack of balance between their hoped for and feared possible selves would demonstrate poorer functioning. Total QLS scores were used as a measure of functioning and whether participants hoped for and feared possible selves were "balanced" was calculated as described in section 3.4.2. Forty-nine of the total 80 participants had completed the QLS and generated three hoped for and three feared possible selves that could be categorised (needed to calculate balance). These 49 participants were included in this analysis of who, 27 demonstrated "not balanced" hoped for and feared possible selves and 22 demonstrated "balanced" hoped for and feared possible selves.



Table 9

*Summary Data for QLS Total Scores for those Participants with “Not balanced” (n=27) and “Balanced” (n=22) Hoped for and Feared Possible Selves*

	<b>M</b>	<b>Median</b>	<b>SD</b>	<b>Skewness</b>	<b>SE of Skewness</b>	<b>Kurtosis</b>	<b>SE of Kurtosis</b>	<b>Range</b>
<b>Not balanced</b>	77.5	76.0	19.98	-.048	.45	-.77	.87	38-111
<b>Balanced</b>	83.91	79.0	21.31	.32	.49	-.37	.95	41.70-124

Total QLS scores were normally distributed for those with “not balanced” and “balanced” possible selves, as demonstrated by no significant skew and Kolmogorov-Smirnov tests:  $D(27) = .10$ ,  $p = .20$  and  $D(22) = .13$ ,  $p = .20$  for those with “not balanced” and “balanced” possible selves respectively. As such an independent samples t-test (equal variances assumed) was carried out to explore differences in functioning between the two groups. This revealed no significant differences in functioning between those with “not balanced” and “balanced” possible selves ( $t(47) = -1.08$ ,  $p = .15$ , one-tailed). This is at odds with what was predicted.

#### 4.6 Summary of hypothesis testing

The hypothesis testing revealed only one significant result: that those who are more optimistic with regard to achieving their hoped for possible selves show better functioning. This finding remained significant after controlling for depressive symptoms. There were no significant relationships between symptomatology (positive or negative symptoms) and optimism.

Considering “balance”, there were no significant differences between those with “balanced” and “not balanced” possible selves in terms of symptomatology (positive or negative symptoms) or functioning.

## **5. Phase One: Discussion**

### **5.1 Overview**

In the following section, the main findings of phase one will be summarised alongside how these findings complement previous research. Strengths and limitations of this phase will then be discussed. The section will conclude by outlining the findings from this phase selected for follow-up in phase two of this study. Clinical and theoretical implications of the findings will be considered following phase two.

### **5.2 Descriptive research questions**

#### **5.2.1 How do people who have experienced FEP describe their possible selves?**

The analysis revealed differences in the number of hoped for, expected and feared possible selves generated in different domains by those who had experienced FEP: more hoped for and expected possible selves fell into “personal development” than any other category whereas “emotional/physical wellbeing” was the most popular category of feared possible selves. However, “interpersonal relations” was the second most mentioned category for all three types of possible selves generated. Overall, the pattern of responses was more similar for expected and hoped for possible selves compared to feared possible selves. The majority of expected possible selves were positively framed (e.g. “I expect to get a job”) suggesting them to be more in line with hopes than fears and implying a relatively optimistic picture of expectations.

Previous research found that the content of possible selves is related to developmentally relevant tasks. Young adults, the age group of the majority of this sample, have been found to most commonly articulate possible selves focused on interpersonal goals (e.g. getting married) and on occupational/educational tasks (e.g. go to university) (Oyserman & Fryberg, 2006). The hoped for and expected possible selves generated by this sample would agree with such findings, indicating similarities with samples of a similar age that have not experienced an episode of psychosis. This may indicate that experiencing FEP may have a limited impact on hoped for and expected possible selves.

“Emotional/physical wellbeing” was the most cited domain of feared possible selves which is consistent with previous research: general “health related” feared possible selves have been found to be cited by all age groups (Cross & Markus, 1991). However, both hoped for and feared possible selves in this area are more frequently generated in later life samples, as health issues become more salient (Hooker & Kaus, 1994). Although this domain may not be ordinarily prominent for young adults, a recent episode of psychosis may increase the salience of wellbeing, particularly emotional wellbeing. This may explain why “emotional/physical wellbeing” is the most generated domain of feared possible selves. Previous research would support this idea with findings indicating that life events or being diagnosed with a chronic illness influence possible selves. Barretto and Frazier (2012) found a positive association between how stressful a life event was perceived to be and the degree to which that event was integrated into an individual’s possible selves: the highest degree of integration was defined as where an event itself had become a possible self. Also, in those diagnosed with a chronic illness, the majority of possible selves domains were found to incorporate the illness (Frazier et al., 2003).

Previous research may afford insight into the differences in the frequency of domains of hoped for and feared possible selves generated. In their work, Hoyle and Sherrill (2006) observed that hoped for possible selves tended to be optimistic and rooted in observations of others while feared possible selves tended to be negative and more likely to reflect personal experience. Results here appear to support the personal experience of mental/emotional distress being incorporated more into feared selves than hoped for selves.

The differences found in how participants described their hoped for and feared possible selves, prompted investigation of other possible differences. There was an interesting discrepancy between how much participants would like their hoped for possible selves to describe them and how much they believed that this will describe them with higher ratings given for the former. This phase of the study does not shed light on factors that may account for this discrepancy.

### **5.2.2 Do individuals who have experienced FEP refer to mental illness when describing their possible selves?**

A higher proportion of participants made reference to mental health problems in feared possible selves than in hoped for or expected possible selves. More participants made multiple references to mental health problems in their feared and expected possible selves than in their hoped for possible selves. Of further note is that, compared to the number of participants who expressed fears about mental health, a much smaller proportion expressed such fears (i.e. as negative references) in their expected possible selves. As discussed earlier, these findings may suggest that experiencing an episode of psychosis has more of an impact on participants' fears for themselves in the future than on their hopes or expectations.

In line with these findings, the above discussion has already highlighted research suggesting that possible selves are likely impacted by illness and stressful life events and why these such events may impact feared possible selves more than hoped for possible selves.

Interestingly, there is some support for the idea that health related feared possible selves may play an important motivational role: Bolkan et al. (2015) reported that, in older adults, specifically health-related feared possible selves were associated with fewer depressive symptoms. The authors suggested that holding such possible selves may motivate individuals to maintain their health and this may indirectly influence their mood.

### **5.3 Hypotheses**

To aid understanding, hypotheses one and three will be discussed separately followed by a combined discussion of hypotheses two and four.

#### **5.3.1 Hypothesis one: those with less optimistic possible selves will have higher levels of negative but not positive symptoms**

Interventions based on cognitive models of negative symptoms have shown promise in improving negative symptoms and functioning (e.g. Grant et al., 2012). These models highlight negative self-appraisals and defeatist beliefs, that prevent active engagement in meaningful activity, as important components in the development and maintenance of negative symptoms (Rector et al., 2005). Previous research has found levels of defeatist beliefs to be significantly associated with negative symptoms, even after controlling for depression (Grant & Beck, 2009). Within the possible selves framework, such beliefs may be conceptualised as being

less optimistic about one's future self. Individuals are then less likely to engage in behaviours that move them towards hoped for possible selves and away from feared selves, i.e. they show lower levels of motivation. It was therefore hypothesised that those with less optimistic possible selves would have higher levels of negative symptoms.

In this study, no significant association was found between negative symptoms and optimism, that is, how much participants believed that their hoped for possible selves would describe them in the future. This is at odds with what was predicted. As predicted there was no significant association between positive symptoms and optimism.

Previous research has highlighted a number of factors that may have contributed to this null finding between negative symptoms and optimism. Firstly, the majority of previous research into cognitive models of negative symptoms has been with chronic samples, mainly those with schizophrenia (e.g. Horan et al., 2010), whereas the FEP sample in this study were diagnostically diverse and demonstrated relatively low levels of negative symptoms. The application of cognitive models of negative symptoms to such FEP samples is currently unclear and results here may indicate that such models are not directly applicable to FEP.

The cognitive model of negative symptoms developed by Rector et al. (2005) proposes that dysfunctional attitudes, namely, low expectancies for pleasure, success and acceptance and perceptions of limited resources all contribute to the development and maintenance of negative symptoms. In this study, how likely an individual believed they were to achieve their hoped for possible self was anticipated to be comparable to these dysfunctional attitudes, particularly low expectancies for success.

It may be that such a way of conceptualising dysfunctional attitudes is too restricted and that this contributed to the lack of association found here.

Furthermore, it may have been that a particular component of negative symptoms, namely avolition, could be related to optimism rather than global negative symptoms. A RCT of adapted cognitive therapy (CT) targeting self-defeating beliefs in 'low functioning patients' with schizophrenia (Grant et al., 2012) found improvements in motivation (measured by the avolition-apathy scale on the Scale for the Assessment of Negative Symptoms) rather than negative symptoms overall.

In one study, those experiencing FEP were found to have significantly more dysfunctional attitudes than a control sample and that these attitudes were significantly positively correlated with negative symptoms (Ventura et al., 2014). One difficulty in this thesis is not being able to ascertain if the sample here is comparable to other psychosis samples, particularly FEP samples, in terms of dysfunctional attitudes. The FEP sample here appeared to demonstrate relatively high levels of optimism about their future possible selves. This may be indicative of having less dysfunctional attitudes than found in previous research and could account for the different findings here.

Previous research has suggested that only when possible selves are linked to realistic plans and strategies that guide an individual toward a hoped for possible selves (or away from a feared self) do they exert a motivational influence (Prince, 2014). In this sample, it may be that participants are relatively optimistic about achieving their hoped for possible selves but that this does not translate into higher levels of motivation (lower levels of negative symptoms) because their possible selves are not linked with such strategies.



In the only previous study to examine the relationship between aspects of possible selves and psychotic symptomatology, Norman et al. (2014) found that higher levels of negative symptoms were associated with lower scores on incidences of current and future positive self but unrelated to current or future negative self. Although this method of measuring possible selves is different to that used in the current study, the differential relationship between negative symptoms and positive self and negative self suggests that the relationship between how individuals feel about their future possible selves and negative symptoms may be more complex than the linear relationship hypothesised. It may be that there are other factors impacting on the relationship, such as beliefs about self efficacy (Ventura et al., 2014) or competing beliefs about feared possible selves. This latter point is particularly pertinent considering differential findings on the motivational influence of hoped for and feared possible selves (Aloise-Young et al., 2001).

### **5.3.2 Hypothesis three: those with less optimistic possible selves will demonstrate poorer functioning**

This study found a significant positive correlation between optimism and functioning, i.e. those who are more optimistic about achieving their hoped for possible selves show better functioning. This is in agreement with what was predicted. This relationship remained after controlling for depression. This is in line with findings from the ISREP trial for social recovery-oriented CBT (SRCBT) in FEP (Fowler et al., 2009). SRCBT focuses on fostering hope about the future and positive self-esteem. Those receiving this therapy increased their weekly constructive activity by an average of 12 hours compared to TAU (Fowler et al., 2009). Furthermore, the therapy had a significant positive effect on beliefs about self which were found to

mediate improvements in activity (Hodgekins & Fowler, 2010). As in the current research, this finding indicates a link between positive self-beliefs and functional outcomes in FEP and suggests that these beliefs are important in motivating individuals to engage in constructive activity.

Other research with FEP samples has demonstrated the importance of beliefs about self in functional outcomes: self-esteem (a related construct) early in the course of FEP has been found to be associated with functional outcome at six months but not with remission of symptoms (Vracotas, Iyer, Joobar, & Malla, 2012) and more dysfunctional attitudes about one's self have been found to be negatively correlated with global functioning (Ventura et al., 2014). Focusing specifically on positive self-beliefs may be important in facilitating positive functional outcomes for those experiencing FEP.

Additionally, subjective models of recovery from FEP have emphasised the importance of holding a positive sense of self and renewing hope in recovery from FEP (Lam et al., 2011; Romano et al., 2010; Windell & Norman, 2013). Considered with the above findings it may be that these constructs help to fuel motivation to engage in meaningful activity.

**5.3.3 Hypothesis two: those with a lack of balance between hoped for and feared possible selves will have higher levels of negative but not positive symptoms and hypothesis four: those with a lack of balance between hoped for and feared possible selves will demonstrate poorer functioning**

Previous research suggests that having “balanced” possible selves is linked with higher levels of motivation, demonstrated by an increased likelihood of engaging

in positive behaviour (Oyserman & Markus, 1990b). Negative symptoms (but not positive symptoms) have been consistently linked with poorer functional recovery in FEP with one component of negative symptoms, motivation, being independently linked to functional outcomes in FEP (Fervaha et al., 2015). Considering this, it was hypothesised that the lower levels of motivation demonstrated by a lack of balance between hoped for and feared possible selves may be reflected in increased negative symptoms. It was further hypothesised that those with a lack of balance between hoped for and feared possible selves will also demonstrate poorer functioning.

Contrary to what was hypothesised, this study found no significant difference in negative symptoms or in functioning between those with “balanced” and “not balanced” possible selves. There was no significant difference in positive symptoms between those with balanced and not balanced possible selves. It should be noted that some previous studies have found an inconsistent pattern of results with regard to the motivational impact of holding balanced possible selves (e.g. Aloise-Young et al., 2001). It has been suggested that this may be due to different methods of measuring “balance” across studies and particular shortcomings of some of these methods. This may account for the null findings here and will be discussed further in relation to this study in section 5.4.3.1.

Additionally, the null findings may be indicative of a more complex relationship between motivation and possible selves, as suggested by previous research, and that as yet the exact process by which possible selves influence behaviour, and under what circumstances, is still being debated. There may be specific factors in this study that mean that having “balanced” possible selves is not linked to higher levels of motivation but that hoped for or feared possible selves were

more influential in guiding behaviour. As discussed previously, an additional consideration is whether the possible selves held by participants were linked to realistic plans and strategies to guide toward a hoped for possible selves (or away from a feared self).

## **5.4 Strengths and Limitations**

### **5.4.1 Design**

This phase of the study used a cross-sectional quantitative design. A pre-existing data set was used that contained various measures of symptomatology, functioning and possible selves at a particular time point.

There are a number of strengths and limitations of undertaking secondary data analysis. Generally, the use of secondary data is an efficient use of resources such as time and money: projects are able to be completed and findings disseminated in a timely manner and, as such, any contribution to new knowledge is accelerated (Johnston, 2014). The efficiency of secondary data analysis was considered particularly advantageous for this project considering the constraints on time and resources of completing a Clinical Psychology Doctoral thesis. This efficiency allowed for the inclusion of a qualitative aspect (phase two) consequently meaning that the study provided a more comprehensive contribution to the understanding of the topic.

Using secondary data has potential limitations. Usually the study population and/or the measures collected are not exactly what the secondary researcher would have chosen (Smith et al., 2011). In the dataset made available here, the main study measures were all well known with established psychometric properties and the

research questions were designed with the measures in mind. Considering the study population, participants were recruited from a specialist mental health team providing a service for a very specific group of individuals, i.e. those experiencing FEP. This was the population of interest here. In addition, the researcher was able to access the same service to conduct phase two of the study, which is a strength of the current research.

A further potential disadvantage of secondary data is that the secondary researcher was not involved in the processes of collecting, coding and inputting data. As such, they may not be aware if there were any specific problems with any of the aforementioned (Boslaugh, 2007). In order to overcome some of these issues, the researcher gathered as much information as possible about the collection of the dataset. This is detailed in the relevant sections below. Time was also spent “getting to know” the dataset. Consideration was given as to whether it was representative of the population it applied to by comparisons of participant demographics and diagnoses with other data collected in first episode psychosis samples (section 4.3).

The correlational design of this phase only determines if there are significant relationships between variables but does not allow for conclusions regarding the existence or the direction of causal relationships. For example, the study revealed a significant positive correlation between functioning and optimism about future hoped for possible selves but cannot explain whether better functioning causes higher levels of optimism or indeed whether higher levels of optimism lead to better functioning. As data were collected at one time point it is not possible to observe any changes over time, such as how individual’s possible selves might change over the course of FEP.

A particular strength of this phase is the use of an open-ended measure of possible selves. This provides a more detailed picture of how those who have experienced FEP describe their possible selves compared to the study by Norman et al. (2014) where pre-defined lists of possible selves were used. This allows the study to offer more of an insight into how experiencing FEP may impact an individual's sense of self and views regarding their future.

### **5.4.2 Sample**

The heterogeneity of this sample in terms of diagnoses is a strength, being representative of the variety of presentations of FEP seen within EI services. Considering demographic variables, the sample of participants in the dataset is comparable to other EI samples from the region but due to a lack of ethnic diversity the sample is not comparable to samples recruited from other areas in the UK. This could be seen as a weakness, placing limits on the generalisability of findings.

Sample size calculations recommended a sample size of 80. When the dataset were screened for missing data, it became apparent that there were varying amounts of missing data across the study variables and this resulted in some analyses being underpowered.

### **5.4.3 Measures**

#### ***5.4.3.1 Balance***

In this study, an overall measure of “balance” was used due to the relatively small sample size: balance was calculated across all categories of hoped for and feared possible selves. A more specific targeted measure of balance between hoped

for and feared possible selves in one particularly category, e.g. “emotional/physical wellbeing”, or between specific possible selves, e.g. those relating to FEP, may have yielded different results. In research investigating possible selves in academic achievement, researchers commonly examine balance between academic possible selves rather than overall balance. In this area results have consistently found support for the motivational impact of balanced possible selves.

Quinlan, Jaccard and Blanton (2006) have further highlighted that calculating balance by counting the number of hoped for possible selves that are “matched” by a feared possible self in the same domain is problematic. This method does not control for the main effects of hoped for or feared possible selves, nor does it control for the number of possible selves listed. In this study, participants were only asked to generate three hoped for, expected and feared possible selves but it may be that if an open ended measure had been used that the fourth, fifth etc. possible selves listed may have shown participants to have balanced possible selves.

## **5.5 Findings selected for follow up in qualitative phase**

### **5.5.1 Categories of possible selves in those who have experienced FEP**

The descriptive analyses revealed differences in how participants describe their hoped for, expected and feared possible selves with regard to the significance of certain categories of possible selves: hoped for and expected possible selves in the category of “personal development” feature most prominently whereas the most mentioned category of feared possible selves is “emotional and physical wellbeing”. The overall pattern of responses is more similar for hoped for and expected possible selves than feared possible selves.

However, these data do not elucidate anything about how such descriptions and the emphasis of hopes, expectations and fears might have changed as a result of experiencing FEP. It could be hypothesised that the increased salience of fears in the “emotional and physical wellbeing” may be due to the experience of psychosis however it may be that these fears are unchanged by the experience. The similarity between the categories of hoped for and expected possible selves described here to other samples of a similar age suggests that they may not have been affected by the recent episode of psychosis. However, this may not be the case. The qualitative phase of the study will facilitate exploration of these issues by exploring:

How does experiencing FEP impact on the descriptions of hoped for and feared possible selves?

Exploration of expected possible selves was not included in order to focus on collecting more in depth information about hoped for and feared possible selves and in considering what was feasible to explore in one research interview.

### **5.5.2 References to mental health in possible selves**

The analysis revealed that references to mental health difficulties are more common in feared possible selves than in hoped for or expected possible selves. Despite many participants holding feared possible selves about mental health, a lesser proportion described these fears in their expected possible selves. As indicated previously, these findings perhaps suggest that experiencing an episode of psychosis has more of an impact on participants’ fears for themselves in the future than on their hopes or expectations. However, as the data are cross sectional they are not able to shed light on the process of potential change to possible selves with reference to



mental health difficulties, since experiencing FEP. This issue will be explored in the qualitative phase of the study:

How does experiencing FEP impact on hoped for and feared possible selves in relation to mental health difficulties?

Exploration of expected possible selves was not included for the reasons discussed above.

### **5.5.3 Barriers to achieving hoped for possible selves**

The findings indicate a significant discrepancy between how much participants would like their hoped for possible selves to describe them and how much they believe that this will describe them. This raises the question about whether there are specific barriers or beliefs, possibly related to the experience of FEP, that mean participants do not believe they will achieve their hoped for possible selves. This will be explored further in the qualitative phase:

What are the barriers to achieving hoped for possible selves in those who have experienced FEP?

### **5.5.4 Functioning and possible selves**

The hypothesis testing revealed a significant relationship between how optimistic participants are about their future possible selves and how well they are functioning. Accordingly, those who are more optimistic about achieving their hoped for possible selves show better functioning. However, this finding does not illustrate what factors or experiences may have impacted on the relationships. The qualitative phase will be used to explore the question:

What has helped people to remain/be optimistic about achieving hoped for possible selves in those who have experienced FEP?

### **5.6 Research questions for the qualitative interview**

Consideration of the findings from the initial quantitative analysis has guided the development of the following research questions for the qualitative phase of the study:

1. How does experiencing FEP impact on the descriptions of hoped for and feared possible selves?
2. How does experiencing FEP impact on hoped for and feared possible selves in relation to mental health difficulties?
3. What are the perceived barriers to achieving hoped for possible selves in those who have experienced FEP?
4. What has helped people to remain/be optimistic about achieving hoped for possible selves in those who have experienced FEP?

## **6. Phase Two: Qualitative method**

### **6.1 Overview**

This chapter outlines the method for phase two of the explanatory sequential design, the qualitative phase. A review of the previously described qualitative design is followed by a rationale for the use of semi-structured interviews. The epistemological perspective of this phase is reviewed and then the sample and procedure are outlined. A rationale for the analytic approach of thematic analysis is given alongside a description of analytic process. The chapter concludes with a discussion of how quality and rigour were ensured for this phase of the study and consideration of ethical and safety issues.

### **6.2 Design**

#### **6.2.1 Review of the qualitative design**

The qualitative phase of the study involved semi-structured interviews with new participants who had experienced FEP. These participants had not taken part in the first phase of the study but were recruited from the same service in which the quantitative data were collected. Such interviews were audio-recorded, transcribed verbatim and analysed using Thematic Analysis (Braun & Clarke, 2006).

#### **6.2.2 Rationale for semi-structured interviews**

Semi-structured interviews involve the use of a pre-determined interview schedule, allowing the researcher to explore areas pertinent to the research questions. However, the use of open ended questions and a flexible approach in administering the interview schedule, also allows space for participants to raise points not

anticipated by the researcher (Barriball & While, 1994). Semi-structured interviews allow for the collection of rich and detailed information about complex topics, including the investigation of sensitive issues (Eatough & Smith, 2006).

The use of semi-structured interviews in this study was driven by the mixed-methods design with the aim to integrate quantitative and qualitative data and the desire to gain rich data about a relatively unexplored area of research. Semi-structured interviews allow a good balance with the researcher having some control over the data produced, and thus allowing specific areas highlighted in the quantitative phase to be followed up, whilst also allowing participants' to raise other discussion points and discuss their experiences in depth.

### **6.2.3 Epistemological perspective**

The philosophical perspectives adopted for this study were discussed previously in section 2.3.3. To recap, the worldview adopted for the qualitative aspect was that of a critical realist. Critical realism assumes that there is a reality “out there” that exists, independent of observers (Easton, 2010). However, it further posits that this “reality” is impossible to completely apprehend as our observations are moulded by investigative interests and socio-cultural factors (McEvoy & Richards, 2006). Adopting this worldview here allowed the researcher to unpick the reality of participants' experiences in furthering understanding of the research topic (Willig, 2013).

## **6.3 Participants**

Participants were recruited from Early Intervention in Psychosis services in Norwich, a specialist service for young people aged 14-35 experiencing FEP.

### **6.3.1 Inclusion and exclusion criteria**

The inclusion and exclusion criteria were as follows.

Inclusion criteria:

- Aged 16-35 years (although this is in line with the age range of the quantitative data, due to the peak age range for the onset of FEP, it is expected that the majority of the sample will fall at the lower end of this range).
- Males and females
- A diagnosis of psychosis (e.g. schizophrenia, schizoaffective disorder delusional disorder)
- Fluent in English (in order to complete the research interview)

Exclusion criteria:

- A lack of capacity to consent to take part (as judged by the clinical team)
- Those experiencing a level of psychosis and/or lack of insight that would prevent engagement in the interview and where elements of psychosis would be included within possible selves descriptions (as assessed by the referring clinician)
- Those who have experienced more than one episode of psychosis
- Those expressing a significant level of clinical risk (as assessed by the referring clinician)

### **6.3.2 Participant characteristics**

Basic demographic information regarding each participant is detailed in Table 10

below. Each participant has been given a pseudonym so they can be referred to in the results section.

Table 10

*Participant Characteristics*

<b>Participant number and pseudonym</b>	<b>Gender</b>	<b>Age</b>	<b>Ethnicity</b>
P1- “Jenny”	F	27	WB
P2- “Rosie”	F	26	WB
P3- “Mark”	M	34	WB
P4- “Angela”	F	27	WO
P5- “Tom”	M	20	WB
P6- “John”	M	20	WB
P7- “David”	M	21	WB
P8- “Andrew”	M	18	WB

*Note.* F = Female, M = Male, WB = British, WO= White Other

### 6.3.3 Sample size

Within qualitative methods there is an emphasis on the use of small sample sizes. This allows for in depth exploration and understanding of the participant’s narratives and experiences rather than producing a ‘superficial qualitative analysis’, which may occur with a larger sample size (Eatough & Smith, 2006). The aim here was to collect sufficient data in order to draw out themes and gain an in-depth

understanding of the research topic, but not too much as to cause data saturation. In total eight participants were interviewed: this is in line with the recommendation by Braun & Clarke (2013) that between six and ten interviews will produce sufficient data for a small scale project.

#### **6.3.4 Recruitment process**

The primary researcher (PR) presented the study to service managers and clinicians. Leaflets about the study were also made available (Appendix E).

The PR then liaised with clinicians in the team to identify eligible individuals. Before the PR was provided with any personal details, the relevant professional/clinician was asked to discuss the study with potential participants to ascertain their interest and provide them with a participant information sheet (Appendix F and G). The clinicians were also asked to gain verbal consent to be contacted by the PR. This was documented in a research log.

If service users consented, the researcher contacted them by telephone to give more details about the study and answer any questions they had. If they agreed to participate, an appointment time and place was arranged. Participants were given the study mobile phone number should they have needed to cancel or rearrange their appointment.

A minimum time period of 48 hours was allowed between providing the participant information sheet and a research appointment to allow potential participants time to consider whether or not they wished to be included in the study.

## **6.4 Procedure**

### **6.4.1 Development of topic guide**

A topic guide, to inform the participant interview, was developed following analysis of the pre-existing data set and through discussion between the PR and supervisors (Appendix H). Initial questions asked participants to define their current hoped and feared possible selves, which were referred back to throughout the interview. The following questions in the guide were clustered into sections based on the research questions and had the aim of expanding on specific quantitative findings (see section 5.5), in line with the overall explanatory sequential design. The guide was used flexibly in order that participants were involved in directing the interview content and discussing their own salient experiences.

The guide was reviewed by INSPIRE, an engagement initiative to involve service users and carers in mental health research in Norfolk and Suffolk NHS Foundation Trust. Their feedback was used in simplifying the wording of questions to ensure they were easily understood.

### **6.4.2 Interview procedure**

Appointments took place at the clinical base or at the participant's home. At the appointment, the participant was reminded about the study information, given the opportunity to review the participant information sheet, ask any questions and then asked to confirm whether they still wished to participate in the study. Participants who agreed to continue were asked to sign a consent form (Appendix I and J).



Basic demographic information (age and gender) was requested at the start of the interview. The PR conducted all the interviews, which were recorded using a digital voice recorder.

Following the interview each participant received £10 to thank them for taking part. They were also requested to complete an end of study sheet (Appendix K) that asked them whether they would like to review a transcript of their interview and whether they would like to receive a summary of the study findings.

## **6.5 Data analysis**

### **6.5.1 Rationale for thematic analysis**

Thematic analysis (TA) was selected as the analytic approach for the qualitative data. This involves identifying, analysing and reporting patterns (themes) within qualitative data (Braun & Clarke, 2006) to provide a comprehensive and complex account. TA was chosen as it is a flexible approach that can be used across a range of epistemologies and research questions: it is not wedded to any pre-existing theoretical framework like other approaches to qualitative analysis (Clarke & Braun, 2013). This is particularly important considering the pragmatic underpinnings of the study and fitting with the critical realist stance.

### **6.5.2 Process of conducting the thematic analysis**

There have been criticisms of TA, mainly regarding a lack of clear guidelines, researcher subjectivity and a lack of rigour (Antaki, Billig, Edwards, & Potter, 2003). These have been largely rectified by Braun and Clarke's oft cited publication of a comprehensive and six-stage guide for conducting TA: familiarisation with the data,

initial coding, searching for themes, reviewing themes, defining/naming themes, and production of the report (Braun & Clarke, 2006). Such guidelines were followed in this study.

A number of decisions regarding the TA must be made explicit prior to data analysis and reflected upon throughout the process of analysis (Braun & Clarke, 2006). One such decision is whether themes are identified in a deductive (“top down”) or an inductive way (“bottom up”). The sequential explanatory nature of this study, where the aim of the qualitative phase is to elaborate on particular concepts and/or interactions identified in the quantitative data means it is best served by a deductive approach (Trahan & Stewart, 2013). That is, the TA was driven by a particular analytic interest and data coded with the specific research questions in mind. A further decision surrounding the TA concerns the “level” at which themes are recognised, which may be at a semantic level or a latent level. Here, a semantic approach was used, whereby the themes are identified at the explicit level of what participants said. It was still crucial for the researcher to be somewhat interpretative in considering broader meanings and implication of the themes (Patton, 1990).

As previously stated, the analysis was guided by the steps outlined by Braun and Clarke, who emphasise that steps are used flexibly and adapted in the light of specific research aims (Braun & Clarke, 2006).

Familiarisation with the data began with the verbatim transcription of two of the eight research interviews. The remaining six transcripts were transcribed professionally but all were checked for accuracy against the original recordings. Furthermore, all of the transcripts were read multiple times for the sake of familiarisation. During this process any initial observations regarding the data were

recorded in a reflective journal (Appendix M).

Data in each transcript relevant to the research questions was then coded (see Appendix L for an example section of coded transcript) with the process being facilitated by the use of the computer programme NVivo (QSR International Pty Ltd. Version 9, 2010). The aim of each code was to summarise and capture the meaning of the section of data (Braun & Clarke, 2013). The process involved a number of decisions, which were again recorded in a reflective journal (Appendix M).

Visual maps were used to facilitate the exploration and refinement of the connections between codes and the grouping of codes into potential sub-themes or themes. In reviewing and revising candidate themes, the validity of each was checked against the coded data extracts (i.e. does the theme “fit” with the data) and the dataset as a whole (i.e. do the themes capture the meaning of the dataset).

## **6.6 Ensuring Quality and Rigour**

### **6.6.1 Quality criteria**

It is not possible to apply the checks and measures used to establish validity and reliability in quantitative research to qualitative research and, in fact, there are ongoing debates about whether it is appropriate to use such terms to evaluate qualitative research (Long & Johnson, 2000; Rolfe, 2006). There are several sets of published guidelines specifically for assessing the quality of qualitative research (e.g. Elliott, Fischer, & Rennie, 1999; Lincoln & Guba, 1985; Yardley, 2000). For the qualitative aspect of this study, four principles outlined by Yardley (2000) have been adhered to whenever possible. Such criteria were chosen because of their flexibility and theoretical neutrality (Braun & Clarke, 2013), making them appropriate for the

overall pragmatic nature of the study and the critical realist stance taken for this phase. Yardley's quality principles are; sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance (see Appendix N).

### **6.6.2 Reflexivity**

An often cited, and perhaps the most fundamental criticism of qualitative methods is that the process is biased by the views, interests, values, experiences, prejudices and implicit assumptions of the researcher (Braun & Clarke, 2013). As it is acknowledged that it is not possible to set such aside (Webb, 1992), the issue is how to manage the potential downsides of this subjectivity and instead to view this as an "opportunity" and a research tool in itself (Finlay, 1998). One way of managing this is by adopting a reflexive approach, that is, a process of carefully considering of how the researchers' own values, beliefs and assumptions may impact on the research process (Finlay & Gough, 2003). This acts to make the research process more transparent and is increasingly considered a key criterion in evaluating qualitative research (Cohen & Crabtree, 2008).

To facilitate this, a reflective log was kept by the PR throughout the research project. Entries document key methodological decisions alongside a record of the PR's assumptions, values and interests that came to the fore. Facilitating self-awareness in this way allowed examination of how such factors may have influenced the decisions made and the interpretation of the data (Willig, 2013). It is widely recognised that reflective logs enhance reflexivity (Morrow, 2005). Aspects of the journal were discussed at a qualitative research forum at UEA to further promote self-awareness.

### **6.6.3 Credibility checks**

Throughout the analysis credibility checks were included as follows:

- Independent scrutiny of the analysis- a fellow Trainee Psychologist, reviewed an extract of transcript and initial coding (Appendix O). Their views and suggested additions/amendments were discussed in order to aid in verification or revision of codes. Later in the analysis, the same Trainee Psychologist examined candidate themes against a section of data and provided feedback on whether such themes appeared appropriate and/or whether additional information within data had been overlooked. This feedback was used in finalising themes. Whilst being independent, the trainee is presently utilising TA as part of their own research project. They have also undergone specialist training in this method and so is well placed to scrutinise the analysis. The analysis was also scrutinised by Dr Sian Coker (primary research supervisor) and Dr Paul Fisher (panel member and qualitative research advisor) who provided feedback and supervision throughout the process.
- Creating an audit trail- Making use of NVivo for storing and sorting codes generated an audit trail of this process. Additionally, a reflective journal was used to document decisions throughout the analytic process (see Appendix M).

### **6.6.4 Researcher position**

As described above, acknowledging and managing subjectivity is an important aspect of conducting qualitative research. Alongside reflexivity, making one's own position with regard to the research as explicit as possible can aid with this (Pyett, 2003) . This disclosure enables readers to consider researchers' data and conclusions

in a more informed manner and allows them to reflect on possible alternative interpretations (Braun & Clarke, 2013). Furthermore, from a critical realist perspective, it is crucial to recognise and acknowledge how one's own experiences and interests may influence how information is interpreted. The PR's background and position is described in Appendix P.

## **6.7 Health and Safety Issues**

### **6.7.1 Researcher safety issues**

When interviews were conducted at participants' homes a safety appraisal was conducted prior to the visit. Such interviews took place within normal working hours and utilised the "buddy" system, in line with the UEA ClinPsyD Lone Researcher Policy.

### **6.7.2 Participant safety issues**

Participants were informed before the research interview that they may take breaks or stop at any stage, without giving a reason. If participants had become too tired, distressed or unwell to continue they would have been given the opportunity to complete the interview on a separate occasion, however all participants were able to complete the interview in one session.

If a participant had indicated they were experiencing a high level of stress or emotional distress OR they had exhibited behaviour suggestive that the discussion was too stressful (e.g. uncontrolled crying) the interview would have been stopped by the PR. If the participant had been unable to continue, they would have been encouraged to contact their GP or care coordinator or, with their consent, the PR would have contacted a member of their care team to request further advice and

support. A member of the supervisory team would also have been contacted if further advice was needed. Contact details of local crisis teams and voluntary organisations (e.g. Samaritans) would have been made available to participants if appropriate. However, none of the participants interviewed showed or reported any signs of distress and all were able to complete the interviews.

## **6.8 Ethical considerations**

### **6.8.1 Ethical approval**

Prior to commencing any research activities, ethical approval was gained from an NHS Research Ethics Committee and the Research and Development department of Norfolk and Suffolk NHS Foundation Trust (Appendix Q and R). The research adhered to ethical requirements set out in conditions of approval (see appendix S).

The qualitative nature of the research means that the final report contains a selection of verbatim quotes. As such, full anonymity was not possible but any personally identifiable details were removed.

## **7. Phase Two: Qualitative Results**

### **7.1 Overview**

A description of the results of the qualitative data analysis is provided in this chapter. An overview of the four themes and 10 sub-themes developed by deductive thematic analysis is followed by a more detailed description of each of these. Direct quotations from participants are used to support the existence of the themes within the data. The aim of this analysis is to answer specific research questions arising from phase one, the quantitative phase, in line with the explanatory sequential design. The research questions will be addressed in the following discussion chapter rather than in this section.

### **7.2 Overview of themes**

Using deductive thematic analysis, four themes and 10 sub-themes were developed from the data. These are outlined in Figure 2 with the four themes being, “belief in recovery”, “living with uncertainty”, “potential barriers to recovery” and “connectedness and social support in promoting recovery”. Each theme captures an important concept within the data with the associated sub-themes describing different aspects of this in more detail. Selected associated codes for each sub-theme, along with the number of participants that contributed to each theme and sub-theme are detailed in Appendix T. The reflective journal (Appendix M) details the process of theme development and refinement and the rationale for key decisions made during the process.



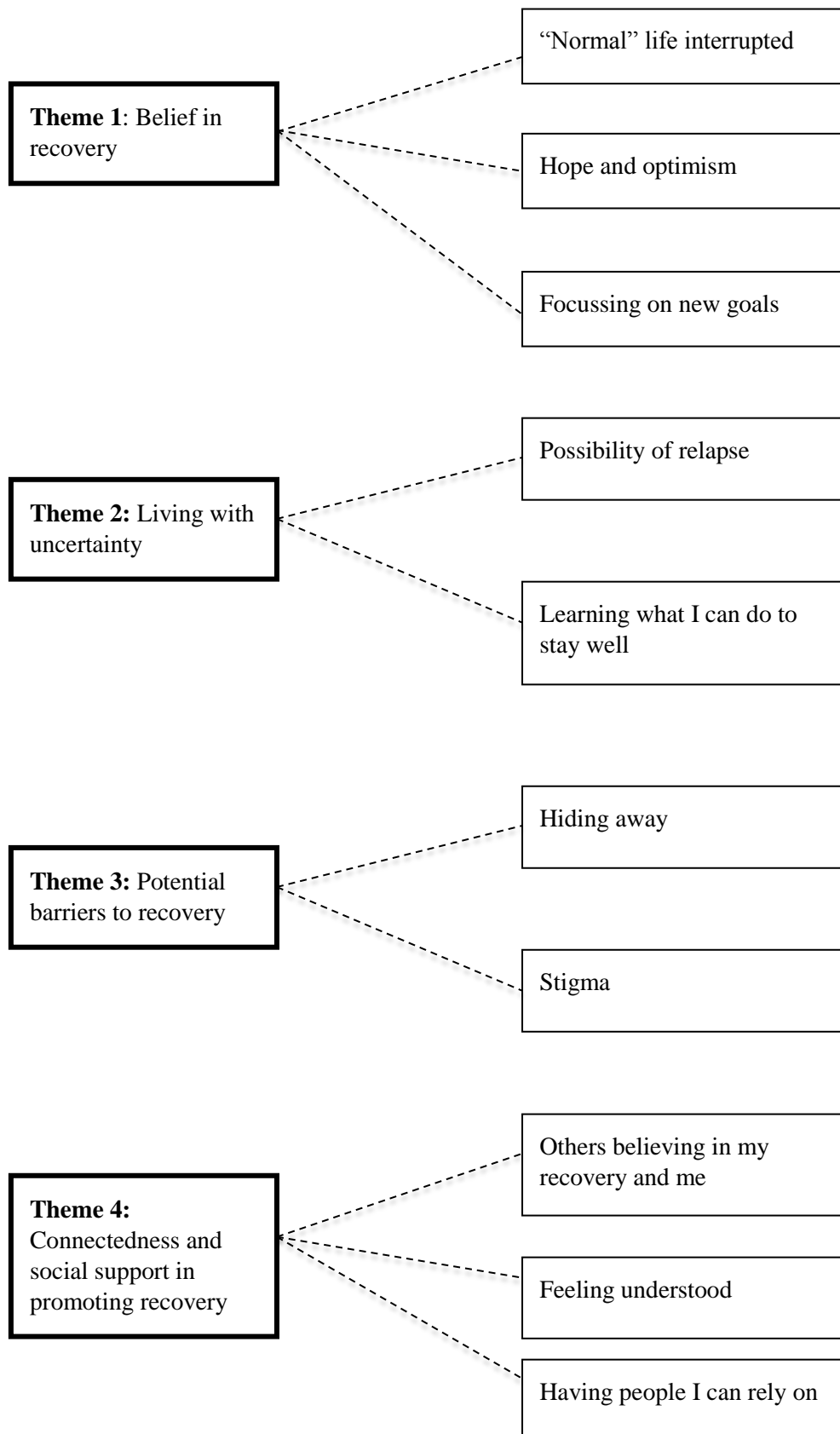


Figure 2. Themes and corresponding sub-themes developed using thematic analysis

### **7.2.1 Belief in recovery**

It was noticeable, both during the interviews and analysis, that the majority of participants appeared to share a belief that recovery from FEP was possible. Holding this belief seemed to allow them to see beyond the “illness” and hope for a “normal” future: it allowed them to think about picking up on life where they had left it before developing FEP or at least to envisage a future that was not restricted or defined by their experiences. It further enabled them to feel hopeful and optimistic about achieving this “normal” future. Throughout their experiences of FEP, participants spoke about developing new interests and goals and had incorporated these into their future plans.

Of note is that “Mark” (who did not contribute to this theme) gave a very different description of his future to the other seven participants: all his future hopes related to getting rid of his symptoms and his future self appeared to have become defined by his “illness”. He was at least seven years older than the other participants and alluded to a significant delay in initially receiving treatment for his symptoms.

The sub-themes supporting this theme are detailed below.

#### ***7.2.1.1 “Normal” life interrupted***

This sub-theme was developed to capture how the majority of participants viewed their experience of FEP. The onset of symptoms, at a crucial developmental stage, led to participants’ lives being disrupted with them making reference to hospital stays, having to stop work, moving back to live with their parents or into supported living and impacting on their social life. However, there was a clear sense that participants viewed this disruption to life as temporary and hoped that ‘normal’ life, a

life not restricted or defined by their experiences of FEP, could continue or was continuing. Tom summed this up by describing his experience of FEP as a hiatus in his planned progression through life: “I might have just been a bit further down my path if I hadn’t been ill ....do you know? So I guess maybe I just feel like I’m a bit behind and catching up” (p. 11, lines 19-20), with John explaining: “I’m getting back to where I was before I got ill. Back on track with life I guess...” (p. 4, lines 1-2).

Not feeling defined or held back by their experiences and believing that recovery was possible appeared to have allowed participants to think about “normal” life continuing. Jenny’s description of this alluded to it being like a chapter of her life that was now over: “I’m just wanting to get on. That is over...you know. That bit of my life. So I just want to get on” (p. 11, line 18-19). John spoke about the importance of realising that recovery was possible in being able to move forward: “....I realised that I’m not stuck like this, so I cannot be Schizophrenic anymore. So that’s pretty awesome” (p. 10, lines 6-7). Tom and David explicitly compared themselves to their peers in illustrating their ideas about hoping for a “normal” future. David explained that: “Everyone else my age is starting to be independent. So I want to be too” (p. 7, lines 9-10), whilst Tom articulated: “It’s just like that normal like routine isn’t it? That people my age think about them, like have kids and get married and that sort of thing. Like I want that too” (p. 6, lines 5-6).

In speaking about their view of life now, both Rosie and Andrew reflected on how their future hopes had remained similar to those they recalled before developing FEP, again suggestive that their experiences had not defined what they hoped for in the future. Rosie articulated: “My hopes are pretty similar....living in my own place, being a good mum. Yeah. The same I guess” (p. 11, lines 12-13). Andrew spoke

specifically about his unchanged career goals: “In terms of career I want to be, like at the moment I do photography and filming and that’s always been what I do and what I want, whether I’m ill or not” (p. 3, lines 13-15).

The idea of “normal” life interrupted is further supported by the developmentally appropriate hoped for possible selves that participants articulated, that is, the content of their possible selves is related to developmentally relevant tasks for young adults, the age group of the majority of this sample. Six participants listed a hoped for possible self relating to their career, such as, “I hope to go to University” (David, p. 4, line 21), and “I hope to find myself a job which is possibly kitchen work” (John, p.3, line 23). Becoming more independent also featured in the hoped for possible selves of five participants. David and John also spoke about this independence in terms of housing with David explaining: “.....living in an independent flat” (p. 7, line 16), and John hoping to progress from living with his parents, “I would like to move out” (p. 4, line 29). Others hoped to gain this independence through learning to drive: “I hope to learn to drive” (Jenny) (p. 15, line 26).

Five participants also listed hoped for possible selves in the domain of “relationships”, again very developmentally appropriate. Jenny hoped for a romantic relationship: “I hope to be in a loving relationship. Like...long term” (p. 15, lines 14-15), whilst Angela spoke about the importance of friendships within her future hopes: “I would like to have my friends circle all the time because it’s really important” (p. 6, lines 20-21). Finding a partner was also important for Rosie but there was a sense that her experience of having mental health difficulties had shaped her ideas about her priorities in any future relationships:

“So my goal now...I don’t want someone who’s rich, I don’t want someone, you know, who gives me everything because, you know I’m not like that, I’d rather have love than money. But I want someone that understands mental health.” (p. 8, lines 5-8)

Participants also spoke about hoped for possible selves relating to their future health: “Positivity and happiness is most important to me” (Andrew, p. 3, line 12), “I just want to be healthy” (John, p. 15, line 7), “....really have a stable like health and “I’d like to stay in recovery” (Tom, p. 6, line 25). Interestingly, none of the participants who contributed to this sub-theme made explicit reference to symptoms of FEP within hoped for possible selves about future health: Tom’s reference to “recovery” was the only reference to anything related to mental health difficulties. Again, this indicates that participants are hoping for very “normal” things for themselves in the future.

Feared possible selves formed less of the conversations than hopes, possibly indicative of the hopeful and optimistic outlook participants had (see section 7.2.1.2). From the fears discussed, it was apparent that these tended to mirror the developmentally appropriate hoped for possible selves, particularly in the domains of career and relationships. David expressed fears about his career plan: “I think maybe if I don’t do so well on this course then I won’t be able to get into University” (p. 11, lines 14-15) and John acknowledged his concerns about not getting back to his life before the disruption of FEP: “I guess I do fear not getting back to myself, yeah. So....job not working and no friends” (p. 6, lines 20-21). Tom and Angela both expressed fears regarding relationships saying: “Maybe just a fear of not being loved” (Angela, p. 13, line 25) and “... it’s like losing like relationships and stuff like

whether it's with my girlfriend or with my mum" (Tom, p. 7, lines 29-30). Specific fears relating to their mental health are discussed in a subsequent theme (section 7.2.2.1).

#### **7.2.1.2 Hope and optimism**

Alongside hoping for and thinking about a "normal" future beyond their experiences, participants also expressed hope and optimisms about achieving what they wanted: a belief that a "normal" life was possible, as Tom described: "...I know I've had difficulties but I still just want a normal life. *And I believe I can have that*" (p. 6, lines 7-8).

Participants spoke about feeling generally positive about their futures: "I feel good about the future. Looking forward to like beyond what has happened" (Jenny, p. 17, line 9) and "I feel really keen and motivated about it at the moment" (David, p. 5, line 26). John felt similarly, despite still experiencing symptoms, "I still have my days where I'm still hearing loads of voices and hallucinating still, but generally less and feeling more positive" (p. 2, lines 27-28). Angela described her positive and optimistic feelings about the future whilst acknowledging her role in ensuring that things remained on track:

"My new tree has to just grow up and I have to keep on watering it and it's going to be all right and it's going to grow. It's going to blossom. You just have to be positive about it." (p. 18, lines 6-8)

Andrew too spoke about the importance of having a positive outlook: "Like if you choose to be optimistic with your decisions then you start to feel more optimistic" (p. 4, lines 17-18).

Participants acknowledged that they had fears about the future but that they were focussed more on their hopes and believed these were realistic and achievable: “We’ve talked about hopes and fears. I guess that as I’ve gone down that line...my fears are there, but it feels like I am more hopeful than fearful” (Jenny, p. 18, line 21). Similarly, John explained: “Maybe I just don’t want to think of fears..ummm..but I guess I feel good about my hopes. They are my focus” (p. 6, line 21). Tom also spoke about the likelihood of realising his hopes, “I think they're going to happen. My hopes that is. They are realistic. I think they can happen. In time” (p. 21, lines 17-18). He was also able to speak about how having clear future goals and knowledge of how to achieve them was key in remaining hopeful about achieving them in the longer term, “I’m so fixed on that I want to do this and I know what I've got to do and whether it happens tomorrow or it happens in 10 years, I reckon it will happen” (Tom, p. 21, lines 22-23).

Rosie clearly articulated that her experiences of FEP had helped her to focus on her hopes, “.... like want to fight harder like, yeah, I have had a mental health illness, but I’m no different to another, the next person without a mental health illness and I could do a job just as good as them” (p. 20, lines 17-19), later adding, “I am more determined to get to my hopes.....to be good. To do good. To live...yeah” (p. 21, lines 5-6).

### ***7.2.1.3 Focussing on new goals***

Participants’ experiences of FEP had led some of them to develop new hopes and goals for the future. For some, these were a direct result of their experiences and for others it was about gaining more of a focus for their future. Three participants spoke about a new goal to work in mental health: to be able to use their experiences to

help others in a similar situation. Rosie explained: “I’d love to work with like either mental health or a peer support worker or care work” (p. 4, lines 36-37), with Tom and David both articulating similar points. “I really want to do something with mental health, like a support worker or assistant practitioner or something like that. I’m looking at doing the mental health degree” (Tom, p. 4, lines 17-18) and “....to study mental health nursing” (David, p. 4, line 25).

Tom further explained that this goal was a consequences of his experiences: “I don’t think I would want to work in mental health if I didn’t have all that experience of it” (p. 9, line 15), whereas for Rosie her experiences had shaped an existing interest in working with people: “My goal was always to do with care work but maybe not mental health. But that’s interested me since I’ve got ill, you know, so...” (p. 4, lines 11-12).

David spoke about struggling to know what to do with his life before FEP and that he felt that his experiences had helped him to gain more focus on what was important to him: “I have focus now....and that is partly due to what has happened” (p. 31, lines 2-3). David recognised this new focus as a positive outcome of his experiences “I guess it is good. Like...to be interested in something new. To have ....ummmm...gained” (p. 13, lines 19-20). Tom felt similarly:

“It’s like, I’ve learnt so much through the whole process even though I’ve had trauma and I’ve been ill and everything, it’s just... that’s now given me this huge new goal of what I want to do and I wouldn’t change it for the world. Someone said that they can change it and they take all my trauma and everything away I wouldn’t at all because then I wouldn’t be me and I wouldn’t have this new focus.” (p. 20, lines 12-17)



John had had to give up a higher education course when he became unwell but he had also developed new goals to focus on, saying: “So I’m not sad about that changing and not doing that anymore. Like...I was...but now I am not. Now I have new goals and I think they are better” (p. 8, line 5). Angela also spoke about focussing on new goals but, for her, there was a sense that this was not a positive outcome of her experiences, unlike the other participants that contributed to this sub-theme: “..it is hard to really be dreaming of something big. I don’t know. I’m focussing on simple things really” (p. 6, lines 19-20), later adding, “I used to be more ambitious. That’s for sure” (p. 17, lines 11-12).

### **7.2.2 Living with uncertainty**

When participants spoke about their futures, there was a prominent sense of anxiety about the uncertainty of their future mental health, specifically the idea that they might relapse. This was clearly related to their experiences of FEP. The recent occurrence of these experiences and the fact they were still being seen within mental health services may have contributed to the salience of this fear. What was also apparent was that participants were utilising a number of lessons learnt throughout their experiences of FEP to manage this uncertainty, namely to reduce the risk of relapse. The data suggest that a degree of fear about the possibility of relapse is protective in that it may guide behaviours and lifestyle choices with the aim of staying well. However, the data here also suggest that holding such a fear could also limit participants’ lives. Each sub-theme is discussed below.

### *7.2.2.1 Possibility of relapse*

When asked about their feared possible selves, all eight participants articulated a fear about relapsing or their symptoms getting worse. John recognised that this was the first fear he thought about: “Well I wouldn't want to relapse into like, yeah, a state. So that's pretty much one. I know that. Yeah. Like straightway when you said that...that...was just the first thing that came to mind” (p. 5, lines 27-29).

David's fear specifically related to being admitted to hospital again: “...I will end up back in hospital” (p. 10, line 25), whereas Jenny was concerned generally with: “getting ill again” (p. 7, line 13). Tom recognised that his fears of relapsing stemmed from the uncertainty around his future mental health: “So I always worry about getting ill again and stuff because you don't know, that can take you at any point” (p. 7, lines 27-28). As opposed to relapsing, Mark spoke about being worried about his mental health getting worse: “I fear that -- I don't know, really, that, you know, I'm going to get worse and the voices are going to get worse” (p. 9, lines 27-28). Andrew simply stated: “My biggest fear is losing it all...that is the only fear, is losing it all, my mentality” (p. 6, line 18). Some of the subtle differences in participants' specific future fears regarding their mental health appeared to stem from their current experience of symptoms. For example, Mark spoke about still struggling with psychotic symptoms whereas others spoke about being in recovery or managing residual symptoms well.

Angela specifically linked her future concerns about her mental health to having had mental health difficulties, also alluding to the idea that such fears may fade with time but again that there is uncertainty about this:

“Ummm.....because of what’s happened. I think the fear of, kind of, losing your mind. I think that will always be with me. Maybe it will feel less like a fear over time. But I don’t know how long that will take.” (p. 23, lines 1-3)

Considering whether participants thought of these fears as a barrier to achieving their goals, Rosie articulated the dilemma she faced:

“That little fear that you hold onto that you might get unwell and that...and then you’re like, “I’m not going to do this because of that,” then you will never leave the house. You’ll never... ..you’ll never get to your goals.” (p. 21, lines 17-20)

Rosie was aware that holding on too tightly to the fear of becoming unwell would impact on what she felt able to do and, in essence, prevent her progressing in life. Tom felt that his fears were not a barrier to moving forward: “Well it plays on my mind a bit but it's not enough to affect my goals and what I want to do” (p. 18, lines 17-18), and Andrew reflected on how his fears were important in motivating him: “It’s a hard subject because there’s fears, but it’s like I have to understand and respect that I’m going to have them. I have to have fears so I can push past them” (p. 6, lines 10-11). Conversely, David and Jenny both acknowledged their fear of relapse as limiting. David saw this fear as a slight barrier: “It’s just there...not a good thing and maybe just a bit of a barrier...but not too much” (p. 18, lines 18-19), whilst Jenny spoke about how living within limits had an impact on what she could do: “Just staying within limits that might be different now to before...So, I suppose it does stop me from doing certain things” (p. 9, line 8). David further acknowledged being somewhat preoccupied with becoming unwell: “I spend a lot of time thinking about it

when I could be thinking about something else. Yeah. Getting unwell...you know” (p. 16, lines 27-28).

Evidently, participants felt differently about the impact of holding a fear about relapsing on their lives, varying from it being motivational to being a barrier. It may be that this variation can be accounted for by the degree of anxiety and preoccupation with the idea of relapse: the more afraid and/or the more preoccupied a person is with the possibility of relapsing, the more limiting this fear becomes. It may also be related to the how well participants believe they could cope with future relapses. For some, having learnt that they could cope with their symptoms reduced the anxiety of relapses. Angela explained: “ When it happens now, I’m just like, “Oh, it’s one of those times. Okay, I shall just stay calm” (p. 5, lines 17-18). Tom also spoke about feeling a sense of certainty about being able to cope:

“I’ve come over it like so many times now that if I do get ill again, then it’s just getting ill, isn’t it? Like getting a cold. And now I know what will happen and what will help. Like when you get a cold (laughs).” (p. 18, lines 22-24)

#### ***7.2.2.2 Learning what I need to do to stay well***

Participants spoke about learning a number of lessons from their experiences of FEP. The majority of these related to learning how to look after their mental health, in terms of lifestyle modifications, potential triggers or understating their limits, in order to prevent or reduce the likelihood of future relapses. Implementing such lessons seemed to help participants tolerate the uncertainty about their future mental health.

John directly recognised that fears about his mental health deteriorating had taught him something: “Yeah...it is a fear. Everything going pear shaped and all that scary stuff getting worse. I think I've learned my lesson or lessons out of that” (p. 6, lines 6-7), adding later that “I think...every day I get a new lesson or have something that will keep me more sane” (p. 12, lines 22-23). Rosie talked more about the impact of her overall experience of FEP, “...it's kind of like it's taught you how to stay well a little bit” (p. 10, lines 1-2). Both Tom and David felt they had gained important knowledge about their mental health saying, “...just how to deal with psychosis and like what to do like when I'm ill” (Tom, p. 20, lines 30-31) and “I know more. I know what to do. I have help” (David, p. 18, line 10).

Participants discussed learning about specific lifestyle modifications they could make to help them stay well, recognising that they had some control over and responsibility for their future mental health. John explained that, “Basically, yeah. I don't want it and need to do positive stuff to avoid it. Yeah. So I guess it helps me. It's another lesson learnt. How to stay well and what is positive to do...you know?” (p. 9, lines 11-13). David and John spoke specifically about learning about the importance of reducing their drug use in staying well. David explained that he was more careful with respect to this saying, “I make sure it doesn't go over the top” (p. 11, line 2). For Andrew, being mindful of triggers and how to eliminate these was an important lesson in safeguarding his future mental health: “So, like for me it's about all those small things that make me stressed, that make me feel negative, all those small things I don't like. It's about eliminating them, learn how to eliminate them” (p. 4, line 25-27).

Both Jenny and John spoke about how they have learnt to look after themselves as a result of their experiences, an important lesson in terms of reducing the likelihood of future relapses. John explained: "...leaning to respect like and look after myself" (p. 12, line 18). When Jenny spoke about this there was a sense that she had learnt what her limits were and was "careful" about pushing herself beyond these: "Maybe I am just careful. I just look after myself and put myself first now" (p. 9, lines 16-17). Angela also spoke about being mindful of her limits, specifically in terms of when she should return to work: "It's important not to be pushed to return to work" (p. 15, line 30).

Andrew used the metaphor of playing music to describe a powerful lesson in learning what was helpful with regard to his mental health. He explained that, for him, learning to live in the present moment rather than spending too much time looking back or worrying about the future had been key in helping him to live well:

"The past will hold you back. To move forward to the future you do have to pause just like when music is playing. And if you're always rewinding ...you can't actually hear the music, you can't concentrate on what's going on. When the music is playing, you can listen to the moment and enjoy it and take that in and actually have some sort of sense of meaning of what's going on...if you're pushing forward, you're just going to get yourself lost in the chaos. So, the best moment is the present moment. The only real moment is the present moment. The future and the past do not matter because it hasn't happened yet or it has happened. You can't change it or you can choose it. So, live in the present moment, make the changes you can now while you have the ability to." (p. 8, lines 21-33)

John and Tom described the importance of learning how and when to ask for help, again a lesson in knowing what their limits were: what they could cope with on their own and the value of “outside” help in managing their mental health. John spoke about needing help from his parents: “I was like no, it's too much for me. I need to spend time with my parents now” (p. 14, lines 29-31), whereas Tom described seeking help from professionals: “Yeah because I know all the team really well now, so as I'm picking up the phone and just saying that I need a bit of extra support right now...” (p. 21, lines 8-9).

Underpinning many of the important lessons learnt through participants' experiences of FEP seemed to be how much they had had to “grow up” throughout the process. Participants' viewed this as a positive. Rosie explained: “But in a way, it's made me, you know...it's made grow up a lot and it's made me understand” (p. 24, line 13). Tom described the process in terms of life experience: “I have learnt so much. So much. Like I said it is like this crazy amount of life experience and you just have to grow up” (p. 19, lines 5-6), and for John there was also a sense of learning the value of life: “I've become so much more reflective. Like, just growing up and stop being an idiot and taking everything and everyone for granted. You just learn not to do that” (p. 13, lines 1-3).

### **7.2.3 Potential barriers to recovery**

During their interviews, participants spoke about a variety of things they felt had held them back during their recovery journeys. In recognising these barriers, some had been able to overcome them but acknowledged the difficulties in doing so. An early consequence of developing FEP was becoming socially isolated and struggling to engage in meaningful activity, such as employment. Participants

recognised the importance of overcoming this isolation and gaining a sense of meaning and achievement in life for their recovery. Many spoke about concerns regarding the stigma of having mental health problems as a barrier to doing just this and, as such, this was also a potential barrier to recovery. Interestingly, some participants' fears about stigma were not realised if/when they were able to confide in others. Each sub-theme is discussed below.

#### ***7.2.3.1 Hiding away***

Participants referred to the social isolation they felt at times: their experiences of FEP had disrupted their social lives and opportunities to engage in meaningful activity, such as working. Tom explained that: "I lost a few friends" (p. 14, line 17), and Mark described difficulties socialising: "I don't like spending time with people because I hear the voices in my head" (p. 8, line 15). Jenny spoke about withdrawing when things got difficult: "...I suppose so because like if you have a bad day, I won't go out" (p. 9, line 6). Whilst this withdrawal was a common experience, participants recognised this as a barrier to recovery and the importance of overcoming this. In explaining what had been helpful for his mental health, John explained: "Just taking it a day at a time and doing positive stuff and not hiding away" (p. 15, lines 30-31).

Angela described the importance of socialising in helping her mental health:

"Because when you are mentally ill, I'm feeling very like unmotivated. I just can't do anything. Nothing to focus on. Nothing is satisfying. But if you just meet somebody and just drink a cup of tea and that is ceremonial itself. You just hear or tell a sort of a joke even though it's the same joke you heard plenty of times. It's still something... like some kind of important...like I'm



on a desert island, seeing like a flower growing. You see there is life. There is potential. There is the hope that it will be okay.” (p. 20, lines 15-21)

John and Mark both had positive experiences of a social group where once again they recognised the positive impact of social contact on their mental health. Mark explained the challenge this posed for him but acknowledged that it was helpful: “I go for my social club...And I mean, that scared me to even do that, but when I get going, I’m all right” (p. 18, line 2-3). John highlighted the importance of the relaxed approach of the group, “...there's a group which has been really useful like you can either sit back and or you can be in the group and talk to people” (p. 16, lines 20-22). He further reflected on the general importance of socialising in helping him make progress, “I think I needed to go outside and to talk to people and I don't want to go back to what I used to be and stay in my room or sleeping or something” (John, p. 9, lines 2-4).

“Hiding away” in terms of not working was also acknowledged to be a barrier to recovery. David and John both spoke about the importance of overcoming this for their mental health. John explained: “I have found like working in a kitchen, I did two and a half months there.... I found it really useful for my mental health” (p. 4, lines 11-13). David highlighted the importance of employment in feeling a sense of achievement: “Definitely work helps with thinking about the future. Keeping busy. Like...you know...achieving. And moving forward” (p. 22, lines 7-8), further adding, “it makes me feel kind of like I’ve achieved something when I’ve had a good day at work” (p. 22, lines 16-17).

More generally, Andrew spoke about the importance of goal setting in helping him become more active and move forward:

“If you’re running around the football pitch and there’s no goals, then why are you playing the game because there’s no point? If you’re not scoring the goals, if you’ve got nowhere to go there, then what is the point?” (p. 2, lines 15-17)

### **7.2.3.2 Stigma**

Participants highlighted concerns about how others might respond to their mental illness: they worried about being judged negatively and discriminated against. John explained: “ I guess because you never quite know how others might respond. And...you know...I guess I was a bit worried about judgement or...stigma and stuff” (p. 11, lines 24-26). Such anxieties interfered with recovery in a number of ways.

Angela explained that her concerns had made it difficult for her to seek help initially: “...but before, a bit difficult because I thought that maybe no one would understand me because they were really... my mind was really a mess” (p. 5, lines 26-17). For Rosie, it was having an impact on confidence in applying for jobs: “With getting a job, I wonder if I’ll say I’ve had mental health difficulties and ...with that then it will put people off” (p. 19, lines 32-33). Tom expressed similar concerns:

“I’m not doing anything with my time or anything I’m just kind of mooching about and I want a job and everything and it’s just like the fear of rejection and nobody wanting you because of that like...because I’m different.” (p. 8, lines 26-29)

Meanwhile, fear of how others might respond made social inclusion difficult for Jenny: “I didn’t tell anybody for a long time. My friends didn’t know” (p. 19, line 18), she later added: “I just didn’t want people to know. I just didn’t want people to

think that I'm weak, I suppose" (p. 19, lines 26-27). Mark had not told his family about his difficulties, "I haven't told my family I'm schizophrenic. I just told them I got bipolar. So, you know, I would never come clean with that (p. 16, line 28), adding his reason as, "It's the stigma of it" (p. 17, line 2). He further articulated that: "no one wants to be schizophrenic" (p. 18, line 4). It seemed that, for Mark, the concern about how others might respond had prevented him fully accepting his difficulties. He particularly struggled with the term "schizophrenic" because of the: "the media and what people think of about schizophrenic" (p. 17, lines 13-14).

Interestingly, those participants who were able to overcome their fears of being judged negatively by others spoke about having positive experiences. John explained that: "I've just got used to telling people I've got a mental condition now" (p. 11, lines 25-26). When asked how people had generally responded he acknowledged: "No real judgement or stigma from others. Cool really" (p. 12, line 1). Angela also reflected on her experiences positively: "England is one of the best ones to accept that mental illness is one of those common things" (p. 16, lines 29-30). Although Tom and Rosie had had some negative responses to sharing that they had mental health difficulties, both felt they had gained from this. Tom explained: "The stigma I've had and stuff is kind of just you take it and then you learn from it sort of thing..." (p. 16, lines 17-18), whilst Rosie articulated that: "I've got really strong. Because even though people have been so negative, that's actually just made me stronger" (p. 22, lines 25-26).

#### **7.2.4 Connectedness and social support in promoting recovery**

The importance of feeling connected to and having support from other people, including professionals and friends and family, was consistently highlighted as an

important factor in participants' recovery. However, certain aspects of that support were identified as being particularly valued. It became apparent that it was important for those supporting participants to remain hopeful and positive about the future and to see beyond the "illness": to believe in the person and see recovery as more than just symptom reduction. Participants identified the importance of feeling understood and the sense of connectedness that followed this. Contact with other people with mental health difficulties was key in this. It was also evident that having a dependable support network during the most difficult times was an important factor in participants' recovery journeys. The sub-themes supporting this theme are discussed below.

#### ***7.2.4.1 Others believing in my recovery and me***

Tom articulated the importance of professionals holding hope and remaining positive in helping with and promoting his recovery:

"My CPN... when I was in my lowest point, my last hospital admission, she always had that hope that I'd get over it and I'd come out and do something amazing and all this. And she'd always tell me every time she saw me it was just that little push that just keeps you going and just knowing that someone believes in you." (p. 13, lines 23-27).

David echoed this when speaking about he had found helpful: "they always, you know...kind of...have faith" (p. 19, lines 3-4). John also spoke about the value of professionals remaining hopeful about recovery: "I've only learnt that because of people around me being so optimistic and treating me...like...normal, I guess. And just talking about a normal future" (p. 10, lines 15-17).

Rosie and Jenny both stressed how much they valued professional support focussing on wider factors, not just on treating their symptoms. When speaking about her care co-ordinator, Rosie explained:

“She supported me not just with my mental health, but everything...because, you know, she believes in me, she believes.... She’s always said to me...

“You’re still a really good mum.” And she just said, when I’ve been feeling a bit like, oh, you know, she’s just been amazing.” (p. 13, lines 22-25)

Jenny gave specific examples of things her support worker had helped her with that had helped her:

“Rather than keeping you in a kind of sick kind of thing....they focussed on life. If I didn’t have her then I don’t think I’d be like I am now. She helped me a lot. She helped me. She got me a bus pass. She helped me get out when I refused to leave the house.” (p. 8, lines 8-11)

When Tom described his experiences, he again highlighted the hopeful approach in planning for the future and also appreciated being at the centre of his care:

“Just everyone has been really supportive and it's like I've always been the centre of the plan and it's like I've always known what the plan is. And we have always planned ahead. Planned to stay well and get on.” (p. 12, lines 25-27)

#### ***7.2.4.2 Having people I can rely on***

Having people they could rely on for support in the most difficult times was identified as being important for participants, a sense that people had and would continue to stick by them. This was something that Jenny highlighted when speaking about the support of her family: “They were just there every time I needed them, they’d be round” (p. 11, line 4), adding, “That was important in helping me to get back on my feet. Like in just giving me space and knowing there was someone looking out for you” (p. 14, lines 5-6). John had really valued the positive support from his parents but also appreciated that that had stuck by him through his experiences: “I think my mum’s a really positive person, same for my dad. They’re both really positive people, so they kind of, you know, sticking by me and I’m kind of learning that” (p. 9, lines 18-20).

For Tom and Angela, it was about having friends they could count on. Tom explained: “And it’s like that typical thing, we can go like when I’m ill or something we can go weeks without talking but then just pick up where you left off” (p. 14, lines 22-23). Angela’s friendships were a particularly important source of support since she did not have family that lived locally: “I would like to have my friends circle all the time because it’s really important. They help me out. I help them out” (p. 6, lines 20-22).

#### ***7.2.4.3 Feeling understood***

The importance of feeling understood was central to participants’ descriptions of helpful influences during their experience of FEP. For many, feeling understood tackled the powerful feelings of alienation that often accompany mental illness. When speaking about feeling understood, participants’ highlighted that this almost exclusively came from contact with other people with mental health difficulties and

that, although they valued support from others their experience was of them “not getting it” or they had a perception that this would be the case

John and Rosie spoke about their concerns about friends who had not experienced mental health difficulties failing to understand their difficulties. Rosie explained that: “Because none of my other friends have ever had a mental health issue ...none of them have ever suffered, so...again its that thing about people getting it”(p. 16, lines 10-12). John expressed similar worries: “So I've got friends, but I think sometimes I can push their limits. I guess I am a bit of afraid of them not understanding. I think that can be hard for other people” (p. 10, lines 29-30).

Both David and Rosie lived in supported accommodation and had daily contact with other people who had varying experiences of mental health difficulties. As Rosie explained: “...where I am now, they’ve all got different mental health issues, psychosis, depression, you know. And they understand more because they’ve got the same” (p. 15, lines 25-27). David had similar thoughts: “...everyone here has difficulties. So people are...just...chilled and understand.” He further articulated the impact of feeling understood as, “Not alone. That is it” (p. 21, line 1).

Jenny mentioned a particularly important relationship for her was with a friend who had also had mental health difficulties: “I got one friend who the same thing happened to her. So it was good to talk to her and that made me realise that I am not alone” (p. 20, lines 11-12). Mark reflected on how it was not always about having explicit conversations with those who had similar difficulties but about just knowing that they understand: “It is helpful to be around other people who are having difficulties with medication and stuff. I mean, no one ever talks about it. We talk about other things, like that. But you know they know” (p. 20, lines 13-15). When

Tom spoke about the importance of feeling understood, he spoke about the role of his family who had also experienced difficulties with their mental health: “...well my family... because we've all had problems with mental health and stuff. They were really understanding in that” (p. 14, lines 6-7).

### **7.3 Additional observations**

It should be noted that the narrative of one participant, “Mark” was largely at odds with the rest of the sample but demonstrates what can happen to an individual's sense of self following FEP. Mark's sense of self appeared to have been engulfed by his experiences of psychosis and he struggled to see beyond his symptoms, diagnosis and the limits that these placed on his life. His hopes for and feared possible selves mainly related to hoping to find a treatment for his (positive) symptoms and fearing not achieving this. His account felt very hopeless. There are a number of factors that may account for these differences. Mark was the oldest participant and at the upper age limit of EI services. This suggests that he might have received intervention at a later stage of his psychosis and elements of his account would also point to a long DUP. His account appeared to be much more in line with findings from those with longer-term mental illness.



## **8. Phase Two: Discussion**

### **8.1 Overview**

The quantitative analysis in phase one of this study guided the development of the research questions for this phase, in line with the overall explanatory sequential mixed methods design. In this section, each of these questions is answered in turn using the themes and sub-themes outlined in the previous chapter. Findings from phase two are also linked with findings from phase one where appropriate. The findings of this phase are then discussed in the context of previous literature. This section concludes with consideration of strengths and limitations of this phase. Clinical and theoretical implications and further research are discussed in chapter 9.

### **8.2 Qualitative research questions**

#### **8.2.1 How does experiencing FEP impact on the descriptions of hoped for and feared possible selves?**

Two sub-themes, “normal life interrupted” and “focusing on new goals” of the theme, “belief in recovery” will be used to answer this question.

The analysis suggests that believing in recovery allows participants to hope for a “normal” life beyond FEP, that is, hoped for possible selves that are developmentally appropriate and not defined or restricted by their experiences of FEP. Whilst acknowledging that FEP had disrupted their lives, participants spoke about hoping to pick up on life where they had left it before experiencing FEP and some reflected on how their hopes remained similar throughout their experiences. In

essence this could be taken to suggest that experiencing FEP may not have a particularly negative impact on the descriptions of hoped for possible selves.

Participants did acknowledge having new hoped for possible selves as a result of their experiences, the majority describing this as a positive outcome. Some had specific new hoped for possible selves related to wanting to work in mental health whereas others now felt the hoped for possible selves were more focused. One participant, Angela, spoke about having new hopes that were less ambitious than before she developed FEP although it should be noted that her hoped for possible selves were very similar to the other participants.

Phase one of this study found similarities between the categories of hoped for and expected possible selves described and that, as in phase two, these were developmentally appropriate being similar to other samples of a similar age that had not experienced FEP. The agreement in the results from both phases of this study suggests that FEP does not necessarily have a negative impact on hoped for possible selves and that, for some, the experience may give new priorities and ideas about what they hope to achieve.

In the qualitative phase of this research feared possible selves formed less of the discussions than hoped for possible selves: this may be indicative of the hopeful and optimistic stance many of the participants had with regard to their future or that talking about fears made them feel somewhat anxious. It appeared that participants had very “normal” feared possible selves that largely mirrored the developmentally appropriate hoped for possible selves, as found in phase one. Participants did however, appear to have developed specific fears about their mental health as a result of their experiences. This is also in line with the descriptive analyses in phase one

which revealed that the most mentioned category of feared possible selves was “emotional and physical wellbeing”. This will be discussed further in section 8.2.2.

### **8.2.2 How does experiencing FEP impact on hoped for and feared possible selves in relation to mental health difficulties?**

This question will mainly be answered by the sub-theme, “possibility of relapse” from the theme, “living with uncertainty”. Reference will also be made to the sub-theme “normal life interrupted” of the theme “belief in recovery”.

Experiencing FEP appeared to have a significant impact on participants’ feared possible selves concerning their future mental health: all eight participants articulated a prominent fear of relapsing or their symptoms getting worse with many explaining that this was a direct result of their experiences. Holding such a fear seemed to have a variety of consequences for participants. For some this seemed protective/motivational, something they were striving to avoid, whereas for others it placed certain limits on their life in an attempt to avoid it being realised. It may be that this discrepancy is related to the level of preoccupation with the fear of relapse or how equipped participants felt to cope with any future relapse.

The experience of FEP appeared to have had less of an impact on hoped for possible selves in relation to mental health difficulties than on feared possible selves. When discussing their hopes for a “normal” future, participants made reference to health and wellbeing but none of those who contributed to the sub-theme “normal life interrupted” made specific reference to symptoms of FEP within these hopes. One participant mentioned the general concept of “recovery”.

The analysis here is concordant with findings from phase one of this study, where again references to mental health difficulties were more common in feared possible selves than in hoped for or expected possible selves.

When the findings of the above two research questions are considered together, it suggests that experiencing FEP has more of an impact on individuals' fears for themselves in the future than on their hopes and expectations. Specifically, the experience of FEP contributes to individuals developing specific fears about their mental health but their hopes and expectations remain developmentally appropriate and do not contain specific reference to their experiences of psychosis.

### **8.2.3 What are the perceived barriers to achieving hoped for possible selves in those who have experienced FEP?**

The sub-themes “hope and optimism” and “the possibility of relapse” of the themes “belief in recovery” and “living with uncertainty” respectively will be used to answer this question. Both sub-themes of the theme “potential barriers to recovery”, “hiding away” and “stigma” will also be drawn on.

In the main, participants felt very hopeful and optimistic about the future: they were focussed on their future hopes (as opposed to fears) and believed these to be realistic and achievable.

As discussed previously, some participants identified that fears about relapsing placed certain limits on their life trying to protect themselves against this happening. It could be conceived that this may then pose a barrier to them achieving their hoped for possible selves. “Hiding away” in terms of being socially isolated, not engaging in meaningful activity and concerns about “stigma” were identified as

potential barriers to recovery. These could also be regarded as potential barriers to participants achieving their hoped for possible selves. When participants were able to overcome these barriers by beginning to socialise, or gaining employment, or by sharing their difficulties with others there was a sense of them being able to move forward with their lives, towards their future hopes.

This research question was developed based on findings from phase one which revealed a significant discrepancy between how much participants would like their hoped for possible selves to describe them and how much they believe these will describe them, with higher ratings given for the former. The discussion has expanded on this by outlining potential factors that may contribute to those who have experienced FEP not believing they will achieve their hoped for possible selves. However, it should be noted that, overall, participants in phase two were largely optimistic about their future.

#### **8.2.4 What has helped people to remain/be optimistic about achieving hoped for possible selves in those who have experienced FEP?**

All three sub-themes of the theme “connectedness and social support in promoting recovery” will be used to answer this question. These are, “others believing in my recovery and me”, “feeling understood” and “having people I can rely on”.

Overall, support from others and a sense of connectedness were highlighted as being important for recovery, that is, crucial in being able to remain optimistic about a life beyond FEP. Participants described a number of elements of the support that they had found particularly helpful. Contact and support from other people with mental

health difficulties resulted in participants feeling understood and this helped to reduce the sense of feeling “alone”. Participants also valued support that was hopeful and optimistic and looked beyond symptom reduction. This was highlighted as the experience that many had of professional support. Lastly, simply having people who stuck by them and whom they could call on in difficult times was identified as being important.

Hypothesis testing in phase one revealed a significant positive correlation between how optimistic participants are about their future possible selves and how well they are functioning. The above discussion, based on the findings of phase two, expands on this by detailing some of the potential factors or experiences that contribute to individuals remaining optimistic about their future.

### **8.3 Discussion of study findings in relation to previous research**

#### **8.3.1 Belief in recovery**

Maintaining a sense of hope and optimism about recovery is at odds with the narrative of those with longer psychiatric histories but is a consistent theme in the literature on recovery from FEP (Romano et al., 2010; Windell et al., 2012). Employing a focus group design, Lam et al. (2011) also found those who had experienced FEP to be largely optimistic about their future with 66.6% of them acknowledging that the experience had been “life enhancing” with regard to developing new value, views, relationships and goals. Participants in this study spoke about a marker of recovery as returning to doing “normal” things (Lam et al., 2011), a perspective shared by participants here. Maintaining a sense of hope is in line with recovery orientated services advocated by the mental health strategy for England

(Department of Health, 2011).

Previous literature suggests a complex relationship between the onset and experience of mental illness and sense of self. In those with long-term mental illness, redefining a sense of self has been identified as a central part of the recovery process (Davidson & Strauss, 1992), with Anthony (1993), explaining that this process involved “the development of new meaning and purpose in one’s life, as one grows beyond the catastrophic effects of mental illness” (p. 15). This is not consistent with findings here where participants were able to retain possible selves as emerging adults, building on strengths and values prior to their experiences and think beyond the “illness”. Whilst the initial onset of FEP did disrupt their lives and halt the pursuit of goals, participants described being able to re-establish hopes and plans to work towards fulfilling their goals. These findings are in line with qualitative research investigating subjective recovery from FEP discussed below.

In a qualitative study by Romano et al. (2010) a grounded theory approach was utilised to develop a model of the recovery process from FEP. A core feature of this model is the idea of individuals reshaping an enduring sense of self following FEP rather than having to redefine a sense of self. Participants’ sense of self was not overshadowed or defined by their experience of FEP, they were able to envisage the future and articulate future goals in line with their developmental stage, such as, career goals and marriage (Romano et al., 2010). Furthermore, the experience of FEP appeared to strengthen an individual’s sense of self in order to manage their illness. Similarly, Connell, Schweitzer, & King (2015) found that those who had experienced FEP forged a stronger sense of self over the course of their recovery. Findings here would agree with this, participants generally acknowledging the positive impact of

their experiences on their self-goals, with many now wanting to help others in similar situations.

With the onset of FEP typically occurring at an important developmental stage in terms of sense of self, it is encouraging that, compared to those with longer term mental health difficulties, FEP appears to have less of an impact on sense of self for participants in the current research. Previous research has suggested that the younger age of the client group, shorter duration of illness and provision of specialist services EI, which typically employ an optimistic, recovery-focused attitude towards treatment (discussed in section 8.3.4) maybe protective with regard to sense of self.

### **8.3.2 Living with uncertainty**

Given the frightening, potentially traumatic and disruptive experiences associated with the onset of FEP, it is perhaps unsurprising that those recovering from FEP articulated fears of relapse in this study. Uncertainty associated with the unpredictable course of FEP and the fear of relapse is a common feature in the narratives of those recovering from FEP (Lam et al., 2011; Romano et al., 2010). Previous research has found possible selves to be sensitive to stressful life events and illnesses with these being incorporated into individuals' possible selves (Barreto & Frazier, 2012; Frazier et al., 2003).

A prominent theme in a qualitative study of depression following FEP was “fear of relapse”: a perception of psychosis as destructive led to participants fearing that if they were placed under too much stress or did not make immediate changes to their lives, then relapse was inevitable (Sandhu, Ives, Birchwood, & Upthegrove, 2013). The authors suggested that this fear led to social withdrawal which contributed



to the experience of post-psychotic depression (Sandhu et al., 2013). Other research with participants with psychosis has found that those who feel powerless to prevent relapse are more likely to develop social anxiety (Gumley, O'Grady, Power, & Schwannauer, 2004) and depression (Birchwood, Mason, MacMillan, & Healy, 1993).

Gumley et al. (2015) developed a measure of fear of recurrence, with good psychometric properties, for use with those with schizophrenia. They found that fears about relapse were associated with increased levels of depression, anxiety, shame, stigma and positive symptoms suggesting that such a fear may block emotional recovery. Functional recovery may be impaired as a secondary consequence. They further discovered fear of relapse to be a significant predictor of time to relapse with greater fears of relapse associated with a shorter time to relapse. It was hypothesised that a greater fear of relapse is associated with more fearful appraisals of salient triggers (e.g. perceptual changes similar to a previous episode of psychosis) which may accelerate the transition to relapse (Gumley et al., 2015; White & Gumley, 2009). Excessive fear of relapse may also act as an internal stressor, which then increases the probability of relapse (Birchwood et al., 2009).

This suggests that in those who hold a fear of relapse, more negative perceptions of the impact of psychosis, excessive fear and more catastrophic interpretations of relapse and feelings of being powerless to prevent relapse are likely to be associated with more negative outcomes. Although participants in this study articulated fears of relapse, overall they also spoke about learning what they could or needed to do to try and prevent this happening, indicative of them feeling some sense of control, and they also had optimistic and hopeful attitudes about the future. This

suggests that holding such fears may not necessarily be detrimental to their recovery.

Reviewing previous possible selves research, some findings have suggested that avoidance goals can have a significant impact on behaviour when people are able to manage the accompanying threat (Rogers & Prentice-Dunn, 1997) and so access the means or resources to avoid such fears (Bolkan et al., 2015). Those who struggle to manage the threat may feel trapped by their feared selves which then have a disorganising effect on behaviour (Hooker & Kaus, 1994). This is consistent with the finding that, to be an effective motivator, possible selves must be linked with plans and strategies to attain or avoid (Oyserman et al., 2006). As participants here consistently articulated plans and strategies to avoid their fears of relapse, this further suggests that holding such fears may positively impact behaviour to help avoid relapse.

Previous research may afford insight into why individuals' feared selves, rather than hoped for possible selves, are directly impacted by their experiences. In their work, Hoyle and Sherrill (2006) observed that hoped for possible selves tended to be optimistic and rooted in observations of others while feared possible selves tended to be negative and more likely to reflect personal experience. Results here appear to be in agreement, with the personal experience of FEP being incorporated more into feared selves than hoped for selves.

### **8.3.3 Potential barriers to recovery**

Stigma is commonly articulated as a potential barrier to recovery in those with FEP. In a qualitative study by Lam et al. (2011) participants recovering from FEP articulated difficulties with subjective internalised feelings of stigma, largely in the

absence of discrimination. For some, fears associated with this posed a barrier to taking up opportunities or disclosing their difficulties. This is very similar to responses given in this study.

In a further qualitative study investigating influences on recovery from FEP, stigma was frequently cited as having a negative impact, identified as reducing social participation alongside harming self-esteem and confidence (Windell & Norman, 2013). This study also revealed that not engaging in meaningful activities hindered recovery. This is in agreement with the research here, where participants also spoke about ‘hiding away’ as a barrier to recovery.

A review of the consequences of internalised stigma for those with mental illness found a robust negative relationship between internalised stigma and a number of psychosocial variables including hope, self-esteem, and empowerment (Livingston & Boyd, 2010). Furthermore, in those with schizophrenia, it has been suggested that stigma has a adverse effect on functional outcomes due to its adverse impact on self-esteem and hope (Yanos, Roe, Markus, & Lysaker, 2008).

Individuals with long-terms psychotic illnesses have been found to feel demoralised by stigma (Spaniol, Wewiorski, Gagne, & Anthony, 2002) and adopt stigmatising views of themselves (e.g. self as dangerous) (Yanos et al., 2008). However, in this study participants remained hopeful and maintained a positive self-image beyond their “illness”. Stigma appears to have had less of an impact on them and this likely benefitted their functional recovery (section 8.3.4 will discuss factors that likely buffered against the negative impact of stigma).

Participants spoke about “hiding away” as a barrier to recovery, seemingly

realising this to be the case by being able to take positive steps to reconnect and get back to work. Engagement in meaningful activities has been found to positively impact recovery in a number of ways in FEP, including through cultivating strengths, connecting with others, changing emotional states and making meaning (Lal et al., 2013).

Poor functional recovery is often reported in psychosis. In a trial of ‘social recovery-orientated CBT’ in those who had experienced FEP, increased time spent in structured activity was associated with changes in positive beliefs about the self (Hodgekins & Fowler, 2010). This demonstrates the impact that self-beliefs and cognitions may have on functional outcomes in FEP. Results of the current study are consistent with this whereby participants’ narratives were dominated by hoped for possible selves that they felt optimistic about achieving. Such positive images of their future selves may have been key in boosting motivation and helping them to re-engage with meaningful activity. Indeed, possible selves research has highlighted that the number of positive possible selves may be strongly linked to motivation (Aloise-Young et al., 2001).

#### **8.3.4 Connectedness and social support in promoting recovery**

The findings here show that the recovery process from FEP is deeply social with a range of positive relationships providing benefits for recovery, which corroborates previous research. In individuals recovering from severe mental illness, relationships with family and professionals and friendships with both “well” individuals and others diagnosed with mental health difficulties have all been implicated in recovery (Schön, Denhov, & Topor, 2009). In FEP, qualitative studies have found similar findings, with social support consistently emerging as a significant

factor in fostering recovery (Eisenstadt et al., 2012; Lam et al., 2011; Windell & Norman, 2013).

Peer support has a long history within mental health services: fellow service users have always provided each other with invaluable support both informally and formally (Davidson, Bellamy, Guy, & Miller, 2012). Narratives of those recovering from mental illness, including FEP, have frequently identified these relationships as providing a deep level of understanding, empathy and reassurance and offering affirmation of experiences which helps with feelings of alienation (Faulkner & Layzell, 2000; Norman et al., 2013). As the value of such relationships has been recognised, more formal peer support roles have been created in mental health services. In the UK, the ImROC programme (Implementing Recovery Through Organisational Change) has explicitly recommended the introduction of peer worker posts. There is a small but growing evidence base that such workers can have multiple benefits for those providing and receiving services (Repper et al., 2013). However, more research is required investigating the benefits and nature of informal peer support in FEP with the findings here suggesting that fostering positive peer relationships is an important aspect of EI services.

As in other FEP research (e.g. Windell & Norman, 2013), aspects of the professional support received were described as important in recovery: nonjudgmental, optimistic, encouraging support all helped participants remain hopeful, determined and engaged in their own recovery. An optimistic and hopeful approach to treatment is frequently identified as a fundamental tenet of EI services (McGorry et al., 2008). Participants here also spoke about valuing professionals focusing on more than just their “illness”. This is in line with recovery-orientated

practices which emphasise a holistic, person centred approach that focuses on enabling an individual to live a meaningful and satisfying life, in the presence or absence of symptoms (Frese et al., 2009). This view of recovery has, in recent times, been adopted as the guiding principle for mental health policy, practice and services, representing a shift away from a treat and cure service (Shepherd et al., 2008). Working in this way also promotes a sense of hope and optimism about recovery and emphasises opportunity and agency.

Zipursky and Charles Schulz (2002) stress “perhaps the most important lesson that the field has learned from studying patients in their first episode of schizophrenia is that of hope” (p. 233). It appears that a hope inspiring service for those experiencing FEP can have a hugely beneficial impact on recovery. This likely buffers against the potentially negative impact of internalised stigma (Warner, 2009) and allows individuals to remain optimistic about achieving a “normal” future.

The ongoing and reliable support of friends and family identified here is also recognised in other research as having an influence on recovery from FEP. The emphasis here appears to differ slightly in that participants spoke about the importance of the support being dependable rather than emphasising the importance of where this support came from, e.g. friends or parents. In the study by Windell and Norman (2013) participants particularly emphasised the importance of parents in their recovery. Similarly, those interviewed by Eisenstadt et al. (2012) made reference to the value of family support. It may be that the support of parents is particularly important for those who experience FEP at a younger age, whereas those who have already achieved some degree of independence when they experience FEP value friendship more (Addington, 2007).

The following section will provide an overview of the strengths and limitations of the qualitative phase.

## **8.4 Strengths and limitations**

### **8.4.1 Design**

This phase of the study utilised a small-scale qualitative design. An oft cited limitation of qualitative research is that it cannot make claims to significance based on the statistical relationship of the sample to the population (Willig, 2013). However, collecting data from a small number of individuals allowed for an in-depth understanding of participants' experiences and thus this phase makes a valuable contribution to the research topic. Findings may also be transferable to similar settings. It should be noted that some of the areas investigated in this phase replicated findings of phase one, the quantitative phase, which included a larger sample of FEP participants.

Understanding how experiencing FEP may impact on possible selves was explored through retrospective reflections, that is, asking participants to reflect on how their possible selves may have changed as a consequence of their experiences. Investigating change processes in this way is not ideal and may be subject to memory inaccuracy. However, considering the initial period following FEP is often overwhelming and chaotic it may be difficult for individuals to engage in research too soon after this experience.

### **8.4.2 Sample**

The participants were all Caucasian and as such the findings may not represent the views of those from other ethnic backgrounds.

Participants were initially selected for the study by treating clinicians. It is probable that they approached those who were well engaged with the service. This may mean that the sample does not represent all those who have experienced FEP given that some individuals may not engage with services. Furthermore, it was ultimately the decision of the service user whether they took part: those who decided to participate may differ, in terms of their experiences, mental state and demographics, from those who chose not to. Though it is not possible to eliminate such a selection bias from research of this type, it is important to be aware that the recruited sample may not be representative of all those experiencing FEP.

### **8.4.3 Data collection**

Some of the research interviews took place in participants' homes with others choosing to meet at the EI clinic base. Participants were given the choice of location to facilitate participation and ensure participants felt at ease in their surroundings. However, conducting the research interviews in the home environment posed a number of challenges including distractions and, on one occasion, the presence of other individuals.

### **8.4.4 Data analysis**

Research questions for this phase of the study were developed to further expand on and explain specific findings from phase one, in line with the overall



explanatory sequential design. As such, the research questions were specific and necessitated a deductive approach to the analysis of phase two. Whilst successfully integrating the two phases of the study is a strength, having such specific research questions for phase two was also experienced as somewhat limiting. Given the limited research in this area, broader research questions may have been more appropriate and the analysis was somewhat constrained by the research questions. However, the findings of the TA are relevant, answer the questions generated from phase one regarding possible selves in FEP and provide additional insights into the recovery processes from FEP.

The focus of TA is to identify patterns across the dataset. It is acknowledged that it may therefore fail to highlight contradictions within individual accounts (Braun & Clarke, 2013). This caused some difficulty in representing the experiences of one participant whose experiences seemed largely contradictory to others. This is considered in the reflective journal and in section 7.3 to increase transparency.

#### **8.4.5 Quality and rigour**

Steps taken to ensure methodological rigour are discussed in Chapter 6: phase two was conducted in line with these plans to ensure trustworthiness. A particular strength of this phase was the independent scrutiny of the analysis by a fellow trainee clinical psychologist and members of the research team. A section of a coded transcript is provided in Appendix K to increase transparency.

It should be noted however that, in line with the critical realistic perspective, data collection and analysis will have been influenced by the assumptions and perspectives of the researcher (Braun & Clarke, 2013). A reflexive approach was

adopted in order to manage this and is a further strength here. A reflective log, widely recognised to enhance reflexivity (Morrow, 2005), was kept throughout the research process with excerpts presented in Appendix M.

## **9. Overall Discussion**

### **9.1 Overview**

In this chapter, key findings are summarised and then strengths and limitations of the overarching mixed methods design are considered. Theoretical, research and clinical implications are then discussed; future areas for research are identified before an overall conclusion is drawn.

### **9.2 Key findings**

The overall findings of this study suggest that experiencing FEP may not necessarily have a negative impact on an individual's hoped for and expected possible selves, covering similar domains to those individuals of a similar age whom have not experienced FEP in both phases. The experience of FEP may actually serve to give a new focus to hoped for possible selves, such as new hopes to be able help others experiencing FEP. Furthermore, individuals in phase two remained relatively optimistic about achieving their developmentally appropriate self-goals, aided by the hopeful and optimistic approach of professionals, contact and support from others with mental health difficulties and dependable social support. Stigma and social isolation were identified as being potential barriers to achieving hoped for possible selves. Findings from phase one indicate that this optimism about achieving hoped for possible selves is positively related to functional outcomes.

Both phases of this study suggested that FEP impacts feared possible selves with future fears about mental health and relapsing becoming more salient. Individuals may be 'trapped' by such fears and this may prevent them from pursuing or achieving their hoped for possible selves. However, findings here suggest that

holding such fears may not necessarily be detrimental to recovery, as through the experience of FEP individuals had learnt what they could or needed do to try and prevent relapse.

In phase one, the hypothesised relationships between having “balanced” possible selves and functioning and negative symptoms were not found. Optimism about achieving hoped for possible selves was not significantly related to negative symptoms as predicted.

### **9.3 Strengths and limitations of mixed methods design**

#### **9.3.1 Strengths**

A strength of the current study was utilising a mixed methods design: integrating qualitative and quantitative methods resulted in a more comprehensive understanding of the research topic and included insights that may have been missed by reliance on a single method. Additionally, by combining qualitative and quantitative approaches, the weaknesses of each approach can be offset. For example, within quantitative methods the “voice” of participants is often lost whereas qualitative approaches allow individuals “voices” to be heard. Conversely, the small sample sizes employed in qualitative research can limit the generalisability of findings and bias can be introduced by interpretations made by the researcher. Such limitations are not characteristics of quantitative research (Creswell & Plano Clark, 2007).

The use of the explanatory sequential design allowed for successful integration of a pre-existing data set in phase one with phase two, the qualitative phase, with a subset of findings from phase one selected for further exploration in phase two.

### **9.3.2 Limitations**

The quantitative and qualitative phases of the study were drawn from different samples due to restrictions on accessing participants for phase two who had taken part in phase one. Creswell and Plano Clark (2007) warn that using different samples in each phase of an explanatory sequential design can threaten the validity of the study if the participants in the qualitative phase are unlikely to be able to explain the results from the quantitative phase. However, in this study participants for phase two were recruited from the same service as phase one, a specialist service for those experiencing FEP. As such, it is possible to suggest that they may be likely to have had similar experiences and similar characteristics to the phase one participants.

A further potential limitation of the study relates to the explanatory sequential design chosen to be able to develop and expand upon the findings generated from quantitative analysis. This design meant that the qualitative interviews and analysis were focused on answering specific research questions with the potential cost of not gaining a broader understanding.

## **9.4 Theoretical and research implications**

### **9.4.1 Possible Selves theory**

This study provides further insight into the sensitivities of possible selves to developmental context, corroborating previous research that the content of possible selves appears to change to reflect developmental processes (Cross & Markus, 1991; Oyserman & Fryberg, 2006). The hoped for possible selves of participants in this study were focussed on developmentally appropriate tasks, such as education and relationships. Considering the link between possible selves and behaviour, holding

developmentally relevant possible selves may play a key role in helping individuals to successfully complete particular developmental tasks and thus be important in personal growth and in navigating lifespan transitions (Markus & Wurf, 1987). If, for whatever reason, an individual's possible selves are not focussed on developmentally relevant tasks it may have a detrimental impact on their progress and longer-term outcomes. Previous research in an adolescent sample supported this with superior academic achievement being associated with holding developmentally appropriate possible selves (Oyserman et al., 2004).

This indicates that possible selves theory can be utilised to understand why individuals may be struggling to navigate particular developmental tasks and transitions across the life course and, potentially, as a point of intervention in guiding individuals to clarify and expand on their possible selves in trying to keep them “on track”. Further longitudinal research at different developmental stages is first required to understand more about formation of possible selves.

This study also suggests that possible selves demonstrate some degree of flexibility. Individuals were able to adapt their possible selves and develop new hoped for self-goals based on new values and interests, namely working in mental health. It appears that the flexibility of possible selves allows individuals to disengage from goals that become irrelevant and create new goals that are focused on areas of life central to current identity and life story (Bolkan et al., 2015).

This study contributes to the understanding of how possible selves are directly impacted by life events, again supporting previous research that such events, whether positive or negative, may come to define an individual's sense of self (Baretto & Frazier, 2012). In this study, the experience of FEP had a dramatic impact on feared

possible selves regarding relapse but seemingly not the same impact on hoped for possible selves. In previous research investigating the impact of stressful life events and chronic illness on possible selves, such a differential impact on hoped for and feared possible selves has not been found (Baretto & Frazier, 2012, Frazier et al., 2003). This represents a novel finding for this study and a potentially fruitful area for future research. In addition, the potentially disruptive and traumatic onset of FEP and the specialist EI support may suggest that FEP is fundamentally different to life events that have been the focus of previous research. It may be there are particular features of life events or external factors such as social support, that make them more likely to be integrated into feared possible selves rather than hoped for possible selves. Further research on a range of life events, chronic and acute illnesses is required to understand more about this.

Previous research has suggested that how well individuals cope with and adjust to life events may be linked with how the events become incorporated into the possible selves repertoire (Baretto & Frazier, 2012). No firm conclusions can be drawn from this study about whether holding feared possible selves, such as fears regarding relapse, were helpful in terms of motivating individuals to take steps to protect their mental health or unhelpful in placing limits on what they felt able to do. It is also unclear how having hoped for possible selves which were not defined by FEP may be helpful or not in coping with the experience. Additional research is required to further understand under what circumstances feared or hoped for possible selves may guide and motivate behaviour. There is currently no consensus on this with previous research indicating differential findings on the motivational influence of hoped for and feared possible selves (Aloise-Young et al., 2001). Furthermore, the cross sectional nature of the majority of previous research does not enable

discrimination of the role of possible selves in the initiation or maintenance of related behaviour. Further longitudinal research is needed to overcome such limitations. Finally the dearth of possible selves research on mental health populations is noted and recommendation for future research is encouraged

The present study has highlighted that the concept of “balance” in possible selves is an area that needs further investigation and clarification. In the present research no support was found for the proposed association between holding “balanced” possible selves and increased levels of motivation. Previous research has also found mixed results in relation to this (Aloise-Young et al., 2001) and further highlights that the exact process by which possible selves influence behaviour, and under what circumstances, is still being debated and requires more research. It seems that this result may be due, at least in part, to a lack of consensus in how “balance” is measured and potential shortcomings of some of these methods (Quinlan et al., 2006). “Balance” is an important area for further study as some research has suggested that this is related to better physical and mental outcomes and in motivating current behaviour (Frazier et al., 2000; Oyserman & Markus, 1990). However, an important task of future research is to develop a standardised measure free of statistical confounds. Similarly, there is not a standardised measure of possible selves making it difficult to synthesise possible selves research and draw comparisons between studies. Developing a comprehensive and coherent measure is also necessary for future research.

#### **9.4.2 Negative symptoms**

Previous research investigating cognitive models of negative symptoms highlighted negative self-appraisals and defeatist beliefs, that prevent active



engagement in meaningful activity, as important components in the development and maintenance of negative symptoms (Rector et al., 2005). Previous research has found levels of defeatist beliefs to be significantly associated with negative symptoms (Grant & Beck, 2009). In this study, no significant association was found between negative symptoms and optimism (how much participants believed that their hoped for possible selves would describe them in the future). A number of potential explanations for this null finding were discussed in section 5.3, including some that were specific to the sample here, namely low levels of negative symptoms and the small sample size. This highlights the need for further research with larger, more representative FEP samples to determine whether this relationship exists.

In this study, those participants who were more optimistic about achieving their hoped for possible selves were functioning better. This suggests that such beliefs may potentially operate as a barrier to engaging meaningful activity but that such beliefs may not necessarily be related to overall negative symptoms. The majority of previous research investigating cognitive models and psychological correlates of negative symptoms of psychosis has been with individuals with chronic psychotic illness, mainly schizophrenia. Findings here suggest more research is required in FEP to understand more about the applicability of cognitive models with this population.

#### **9.4.3 Models of subjective recovery from FEP**

Findings from the current research suggest that the process of subjective recovery from FEP differs from models of subjective recovery from long-term mental illness (e.g. Roe & Davidson, 2005). This study has particularly highlighted that FEP does not appear to impact on sense of self to the same extent as long-term mental illnesses. Participants' did not appear to become engulfed by their "illness" and were

able to continue to hold on to, and remain optimistic about, self-goals and ambitions as emergent adults. As such, recovery from FEP appears to be much more about reshaping an enduring sense of self than necessarily redefining the self. Further longitudinal qualitative studies in FEP populations across a range of geographic locations and with more ethnic diversity would help to gain a border understanding of sense of self in FEP.

It should be noted that one participant in the qualitative phase had a narrative at odds with other participants, describing a sense of self that had become engulfed by their 'illness'. This may be due to the older age and longer DUP of this participant that meant their experiences were more akin to those with long-term mental illnesses than FEP. However, it may be that a proportion of those who experience FEP do become 'engulfed' by their illness and that there are specific experiences and factors that explain why some become 'engulfed' and others do not. Further research is needed to explore this.

## **9.5 Clinical implications**

This study suggests the concept of possible selves can be applied to those who have experienced FEP to help understand how their experiences may have impacted their sense of self and particularly whether this has impacted on their developmental trajectory. Additionally, understanding individuals' possible selves may help clinicians to implement meaningful, person centred, strength based interventions.

The finding that optimism about achieving hoped for possible selves is positively related to functional outcomes suggests that it would be beneficial for interventions for those experiencing FEP to target self-beliefs, particularly in

promoting social rather than symptomatic recovery. Fostering positive self-beliefs about achieving meaningful goals, alongside instilling hope may improve participation in meaningful activity and in turn improve social recovery. Some treatment trials with FEP samples have begun to incorporate these factors into therapeutic interventions (Fowler et al., 2009). It also appears that, subjectively, individuals who have experienced FEP identify social isolation as a barrier to recovery, further highlighting the importance of interventions that target this.

This study has highlighted a number of factors that are important to consider in supporting those experiencing FEP, particularly in helping individuals to remain hopeful about achieving a “normal” future. Supporting individuals experiencing FEP requires a shared, realistic, hopeful message about the future in promoting the view that recovery from FEP is possible, frequently highlighted as a key component of EI services. It also appears crucial that professional support focuses on more than symptomatic recovery, in line with the recovery movement approach. The experience of participants in this study was that professionals were able to promote a sense of hope for recovery from the onset of treatment.

Promoting contact with other service users seems to be beneficial for those experiencing FEP, appearing to reduce feelings of alienation by contributing to the feeling of being “understood”. The advent of peer support workers in mental health services is likely to increase opportunities for formal peer support but findings here suggest that informal contact with fellow service users is also advantageous. More generally, it is important for those experiencing FEP to have a dependable social network around them. Valuing family or friends as this social network is likely to vary between individuals. An important focus for professionals working with those

experiencing FEP is helping them to build and maintain a social network and in educating this network in their role in recovery from FEP.

Clinically, it is also important to pay attention to feelings of stigma as reducing these is likely to aid in recovery. Media campaigns and messages regarding recovery from mental health also have an important role in educating society, breaking down stereotypes and reducing the stigma of experiencing mental health difficulties.

This study suggests that fears of relapse are very salient following FEP. Whilst this in itself may not be undesirable, it is important for clinicians to be aware of this and that relapse planning forms part of interventions in a way that encourages a sense of empowerment about their mental health rather than feeling “trapped” by their fears of future relapse. It may be that interventions targeting the formation and maintenance of fears relating to relapse are also beneficial.

## **9.6 Conclusion**

The aims of this thesis were to apply the concept of possible selves to FEP to understand more about both the impact of FEP on the developing sense of self and on mechanisms underlying negative symptoms, a relatively novel application of possible selves theory.

Findings demonstrate that FEP does not necessarily have a detrimental impact on hoped for and expected possible selves with these covering similar domains to those individuals of a similar age whom have not experienced FEP. This suggests that recovery from FEP is about reshaping an enduring sense of self than redefining the self. The hopeful and optimistic approach of professionals, contact and support from

others with mental health difficulties and dependable social support appear to be key in helping those who have experienced FEP to remain optimistic about achieving their hoped for possible selves and that optimism about achieving hoped for possible selves was positively related to functional outcomes. Stigma and social isolation are potential barriers to achieving hoped for possible selves.

In contrast, experiencing FEP does appear to impact feared possible selves with fears relating to mental health and future relapse becoming prominent. It is not clear whether this is necessarily detrimental to recovery: individuals may become ‘trapped’ by such fears, preventing them from pursuing or achieving their hoped for possible selves however, in certain circumstances feared possible selves may exert a motivational influence. Furthermore, through the experience of FEP individuals in this study had learnt what they could or needed do to try and prevent relapse. More research is required to understand the implications of holding feared possible selves relating to mental health.

Based on these findings a number of suggestions were made about factors to consider in supporting those experiencing FEP and where it may be helpful to focus clinical interventions.

Optimism about achieving hoped for possible selves was not significantly related to negative symptoms as predicted. This may be due to a number of limitations of phase one of this study, such as, the small sample size which limits confidence in statistical outcomes and relatively low levels of negative symptoms in the sample. Further research with a larger, more representative FEP sample would allow investigation of whether this relationship exists and further our understanding of models of negative symptoms in FEP.

The hypothesised relationships between having “balanced” possible selves and functioning and negative symptoms were not found. This may be due to the widely debated difficulties in how to measure “balance”. It also highlights that further research is needed into the precise manner in which possible selves influence behaviour, particularly in pinpointing the conditions and factors that improve or hinder their motivational impact and in establishing the relative importance of hoped for and feared possible selves in motivating behaviour.

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## **Appendix A**

### **Steps taken to address potential threats to mixed-methods design**

#### *1. Assess array of possible quantitative results to follow up*

Quantitative results were reviewed and discussed with the supervisory team in order to develop a clear understanding of which results would be followed up in the qualitative phase. Discussions were also had regarding the development of a topic guide for the qualitative interview to ensure this covered all areas to be followed up. Following the first qualitative interview, the participant's responses were reviewed and the topic guide adjusted further.

#### *2. Determine who can best provide the qualitative follow up*

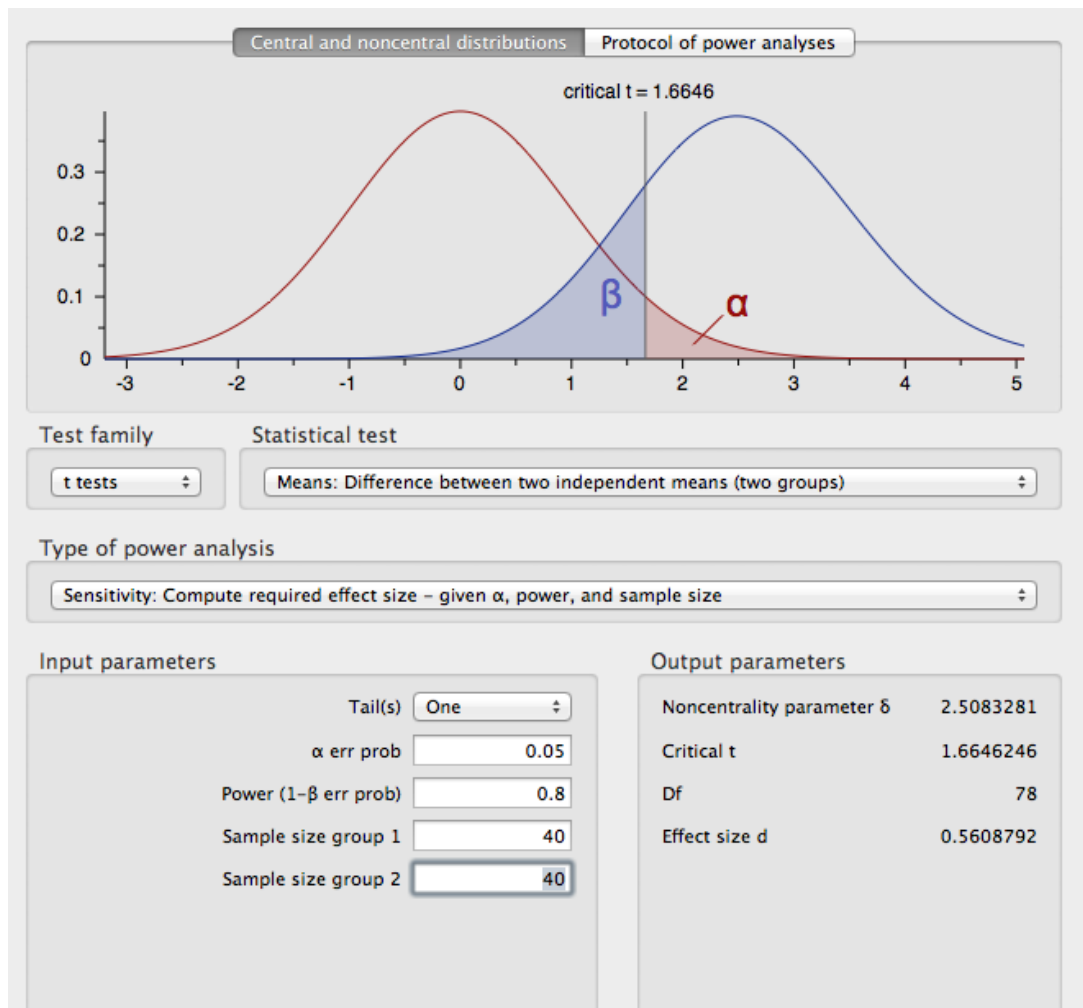
The quantitative data were collected in 2005 and, as such, it was not possible to recruit a sample of the same participants for the qualitative phase. However, recruitment for phase two took place within the same service as the original quantitative data collection. As this is specialist service for those aged between 16-35 experiencing a first episode psychosis, it is likely to be a similar sample to that recruited for phase one.

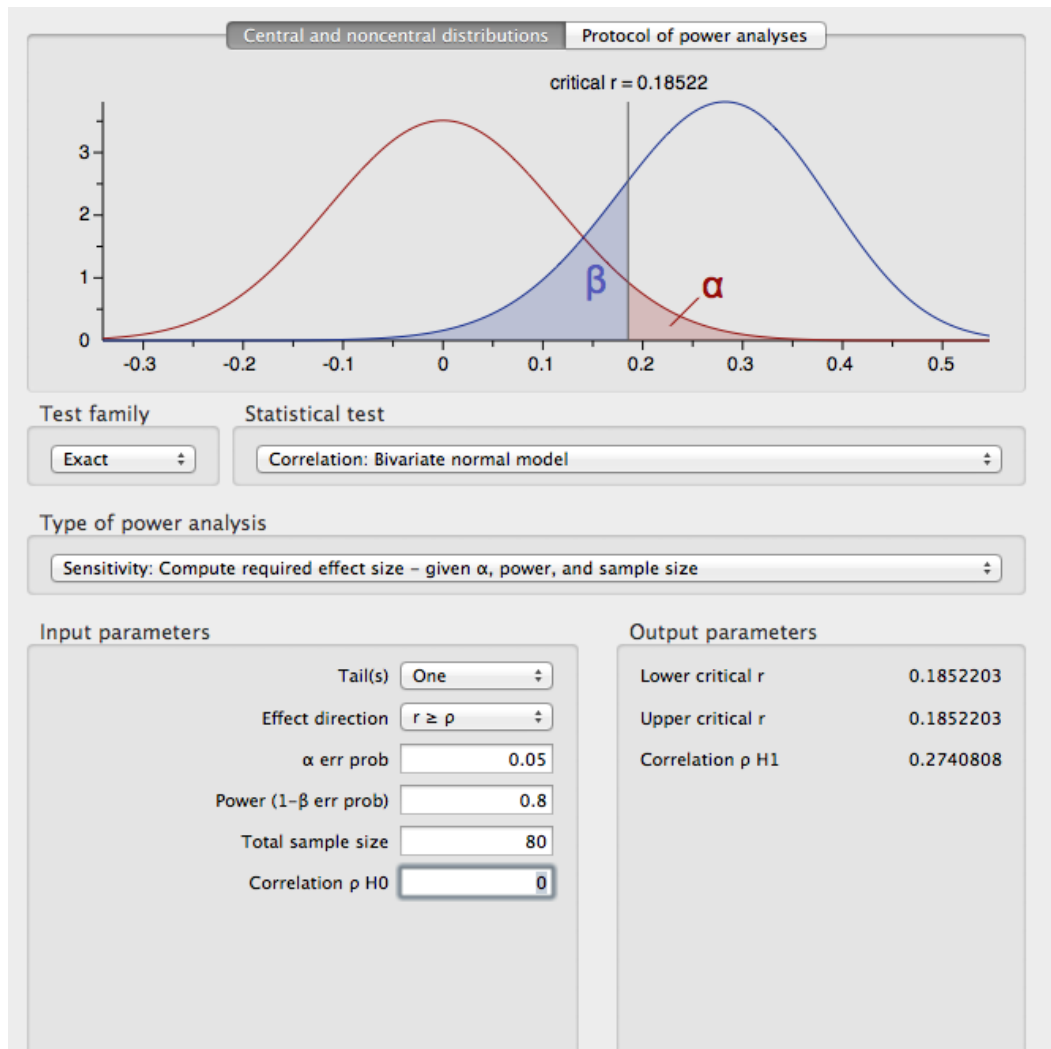
#### *3. Make sure the qualitative explain the quantitative*

As discussed above, the topic guide for the qualitative interview was developed with the supervisory team and then adjusted after the first qualitative interview to ensure the appropriate information was being collected.

## Appendix B

### G\* Power Calculations





## Appendix C

### Possible Selves Interview

Who will you be in the future? Each of us has some image or picture of what we will be like and what we want to avoid being like in the future.

#### Hoped-for Possible Selves

Think about what you would ideally like to be doing in the future.

- In the lines below, write what you hope you will be like and what you hope to be doing in the future.
- In the space next to each hoped-for self, mark NO (X) if you are not currently working on that goal or doing something about that hoped-for self and mark YES (X) if you are currently doing something to get to that hoped-for self.
- For each hoped-for self that you marked YES, use the space to the right to write what you are doing to attain that goal.

I hope to be...	Am I am doing something to be that way		If yes, What I am doing now to be that way in the future?
	NO	YES	

For each hoped-for self rate the following:

- How much does this describe you now?
- How much will this describe you in the future
- How much would you like this to describe you?  
0 = not at all, 1 = a little, 2 = somewhat, 3 = quite a bit, 4 = very much

#### Expected Possible Selves

Think about what you expect to be doing in the future.

- In the lines below, write what you expect you will be like and what you expect to be doing in the future.
- In the space next to each expected self, mark NO (X) if you are not currently working on that goal or doing something about that expectation and mark YES (X) if you are currently doing something to get to that expected self.
- For each expected self that you marked YES, use the space to the right to write what you are doing to attain that goal.

I expect to be...	Am I am doing something to be that way		If yes, What I am doing now to be that way in the future?
	NO	YES	


For each expected self rate the following:

- How much does this describe you now?
- How much will this describe you in the future
- How much would you like this to describe you?  
0 = not at all, 1 = a little, 2 = somewhat, 3 = quite a bit, 4 = very much

#### Feared Possible Selves

In addition to expectations and expected goals, we all have images or pictures of what we don't want to be like; what we don't want to do or want to avoid being. First, think a minute about ways you would not like to be in the future -- things you are concerned about or want to avoid being like.

- Write those concerns or feared possible selves in the lines below.
- In the space next to each concern or feared self, mark NO (X) if you are not currently working on avoiding that concern or to-be-avoided self and mark YES (X) if you are currently doing something so this will not happen in the future.
- For each concern or feared self that you marked YES, use the space at the end of each line to write what you are doing to reduce the chances that this will describe you in the future. Use the first space for the first concern, the second space for the second concern and so on.

I fear...	Am I am doing something to avoid this?		If yes, What I am doing now to NOT be that way in the future?
	NO	YES	

For each feared self rate the following:

- How much does this describe you now?
- How much will this describe you in the future
- How much would you like this to describe you?  
0 = not at all, 1 = a little, 2 = somewhat, 3 = quite a bit, 4 = very much

## Appendix D

### Possible Selves Coding Framework

#### 0 Not Given

When the participant is not able to respond with any possible self then it is included in this group.

#### 1 Personal Development

When the content of the possible self is related to any personal development it is included in this category. Development can be in any area in which learning or time spent planning or working is necessary.

Personal development is defined as:

- Educational references either occupationally or for personal interests. (E.g. Hobbies, college/uni courses, travel.)
- Occupational references. (E.g. Work, jobs, earning)
- Independence from services

#### 2 Possessions

When the content of the possible self relates to material possessions it is included in this category.

Possessions are defined as the following:

- Ownership/lack of any material object (E.g. Home, car)
- Financial references (E.g. Money, debt)

#### 3 Emotional/Physical Well Being

When the content of the possible self relates to any physical or mental well being it is included in this category. This includes emotionally related experiences and specific mental health concerns.

This category includes the following:

- Feelings/emotions. (E.g. Being sad, happy, bad, lonely)
- Physical health. (Physical illness, injuries, severe accidents)
- Mental health references\* (Incl. Psychotic symptoms, stress, hospitalisation, suicide excl. alcohol and drugs selves)

**\*An additional note should be made when a specific mental health reference occurs.**

**Place a '1' in the designated column if present.**

#### 4 Interpersonal Relations

When the content of the possible self relates to other people it is included in this category. As well as references to relationships with family and friends this also includes being alone.

This includes the following:

- Family
- Friends.
- Spending time with others

When rating the possible selves there should be as little subjective decision on the content of the possible self. Only rate the words, as they are in the possible self.



If more than one possible self is mentioned (e.g. Save money and get married) the first self is taken (save money).

If self does not refer to the 'self' in the future (e.g. global warming) it is coded as 'not given'. A balance is found if any of the expected self categories match with any of the feared self categories after the selves are coded. A self can only be used once therefore the range is 0 (no same coded selves) to 3 (all selves match).

## Appendix E

### Leaflet for professionals

#### Who is organising the study?

The study is being organised by Rachel Clarke, a Trainee Clinical Psychologist at the University of East Anglia.

Rachel is being supervised by Dr Joanne Hodegkins.

The study has been granted full ethical approval by the Research Ethics Committee and has also been approved by the local NHS Research and Development Office.

#### Contact details:

**Rachel Clarke**

[Rachel.yates@nsft.nhs.uk](mailto:Rachel.yates@nsft.nhs.uk)

[Rachel.yates@uea.ac.uk](mailto:Rachel.yates@uea.ac.uk)

**07934107691**



#### Research study investigating:

#### Possible Selves in First Episode Psychosis

#### Leaflet for Professionals



### What is the research about?

This study aims to gain an in-depth understanding of how experiencing a first episode of psychosis impacts on what individuals hope for and fear about the future. These hopes and fears are sometimes described as “possible selves”. Previous research findings have demonstrated that possible selves can change behaviour, increase motivation, and are an important consideration in how people adapt to an illness. These concepts are all applicable to recovery following first episode psychosis (FEP) but research is needed to understand more about the significance of possible selves in FEP.

### What will participants be asked to do?

Once they have consented to take part in the study, participants will be asked to:

- Meet with the researcher to take part in a semi-structured interview. This involves questions about their experience of first episode of psychosis and how this has impacted on their hopes and fears for the future. It is estimated the interview will last

about an hour and can take place at their home or the clinic they normally attend.

- Participants will receive £10 to thank them for taking part.

### Who can take part?

People can take part if they:

- Are aged 16-35
- Have a diagnosis of psychosis (e.g. schizophrenia, schizoaffective disorder delusional disorder)
- Are fluent in English language (in order to complete the research interview)

Unfortunately people are not eligible to take part if they:

- Lack capacity to consent
- Are experiencing a level of psychosis and/or lack of insight that would prevent engagement in the interview and where elements of psychosis would be included within possible selves descriptions
- Have experienced more than one episode of psychosis
- Are expressing a significant level of clinical risk

### What will I be asked to do as a mental health professional?

- Identify any service users who might be eligible to take part
- Pass on information sheets about the research to those who are eligible and interested in taking part
- Where service users verbally agree to be contacted about the study, pass on their contact details to Rachel so she can discuss the study further.

Rachel will visit the service regularly to remind you about the study and see if there are service users eligible to take part.

Please do not hesitate to contact Rachel with any questions. Many thanks!

## Appendix F

### Participant information sheet



#### Participant Information Sheet

#### Project title: Possible Selves in First Episode Psychosis

Researcher: Rachel Clarke (Trainee Clinical Psychologist)

Supervised by: Dr Jo Hodgekins and Dr Sian Coker (Clinical Psychologists)

Doctoral Programme in Clinical Psychology, School of Medicine and Health  
Sciences,  
University of East Anglia

We would like to invite you to take part in a research study. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take time to read the following carefully. Please ask if there is anything that is not clear or if you would like more information.

**Who is conducting the research?** My name is Rachel Clarke and I am a Trainee Clinical Psychologist at the University of East Anglia. This piece of research is part of my training to become a Clinical Psychologist. The research is being supervised by Dr Jo Hodgekins and Dr Sian Coker (Clinical Psychologists).

**What is the research about?** This study aims to gain an understanding of how experiencing a first episode of psychosis impacts on what individuals hope for and fear about their future. These hopes and fears are sometimes described as “possible selves”. An example of a hoped for possible selves might be ‘I hope to get a job’ and a feared possible selves might be “I fear not getting a job”.

This kind of research can help mental health services to understand the needs of people who have experienced psychosis, and to develop interventions and services with a focus on enabling individuals to do the things they want to do with their lives.

**Why have I been invited to take part in the study?** I am asking people who have experienced a first episode of psychosis and who have been involved with an Early Intervention Service to take part in this research study.

**Do I have to take part?** No. It is up to you to decide. In making your decision you may wish to seek advice from a friend, family member or trusted professional.

**What does the research involve?** You would have the opportunity to speak with me to ask questions about the study and discuss taking part before you agreed to be involved. If you decide to participate, I would arrange to meet with you at home or at the clinical base you normally attend.

We would spend time discussing your experience of first episode psychosis and how this has impacted on your hopes and fears for the future. You would be asked to say a little about how you came into contact with mental health service, and briefly about the problems you were experiencing at the time. We would also ask you about how the service responded to you and what your main sources of support have been. There are no right and wrong answers, and you are free to decline to answer any question you do not feel happy to answer. The interview will last around an hour.

The interview will be audio-recorded. After the interview you will have an opportunity to ask any questions and raise any concerns you may have. You will receive £10 to thank you for participating. I will also ask if you would like to review a written transcript of your research interview and whether you would like a summary of the research findings when the study is complete.

**What will happen to the information?** I will type out the recording of the interview. This means the information can be looked at in detail with the aim of uncovering common themes that are important in understanding the experiences we have discussed.

The recordings and typed out interviews will be kept at the UEA in a locked storage facility for 5 years after study is complete.

As part of my qualification, I will write up reports of the research some of which may be published. The reports will include some word for word quotes from the interviews to illustrate themes that have been discussed. Although your name will not be included in any reports, the direct nature of the quotes means that complete confidentiality cannot be guaranteed.

Other member of the research team will look at anonymised sections of the information collected from the interview in order to assess the quality of this doctoral research project. This assessment is of me, the researcher, not you as a participant.

**What are the possible disadvantages and risks of taking part?** Some people might find talking about their experiences of psychosis upsetting. Every measure will be taken to minimise the risk of distress. If you do become upset, you will be given the option to take a break or stop the interview altogether. Following the interview, I will remain available to talk to if necessary and will provide details of where you can access support.

**What are the potential benefits of taking part?** It is hoped that by taking part in this research, you will be providing valuable information that will help improve the understanding of the experience of first episode psychosis. This is key in providing the best support to others who go through this experience in the future.

**What will happen if I don't want to carry on with the study?** You may change your mind about taking part at any time, before, during or after the interview without having to give a reason. If you decide you want to withdraw from the study please let me know by contacting me on the email address or phone number given at the end of this information sheet. This will not affect any treatment you are receiving. If you have completed the interview all information relating to this will be destroyed however this will not be possible once the final report has been written.

**Will my taking part in this study be kept confidential?** A note confirming your participation in the study and a copy of the completed consent form will be added to your clinical notes. Your GP will also be informed of your participation. All other information that is collected about you during the course of the research will be kept confidential. However, if you disclose any information which suggests that either you, or someone else, is at risk of harm then I would have to tell someone else. I would always try to discuss this with you first.

**What if there is a problem?** If you have a concern or complaint about any aspect of this study, you may contact me in the first instance. Alternatively you can contact my research supervisors, Dr Jo Hodgekins or Dr Sian Coker (see contact details below). If you remain unhappy and wish to complain formally, you can contact Prof Ken Laidlaw (Director of the UEA Clinical Psychology Course, 01603 593076).

**Who has reviewed the study?**

The study has been reviewed by the Research Ethics Committee (LREC Reference: 15/EE/0188) and the Local Research and Development Department. The study received a favourable ethical opinion and approval.

**Contact Details:**

**Rachel Clarke**

Doctoral Programme in Clinical Psychology  
Norwich Medical School  
University of East Anglia  
NR4 7TJ  
Rachel.yates@uea.ac.uk  
07934107691

**Dr Jo Hodgekins /Dr Sian Coker**

Doctoral Programme in Clinical Psychology  
Norwich Medical School  
University of East Anglia  
NR4 7TJ  
j.hodgekins@uea.ac.uk /[s.coker@uea.ac.uk](mailto:s.coker@uea.ac.uk)/ 01603 593544

## Appendix G

### Parent information sheet



### Parent Information Sheet

#### Assent for participant's aged 16-18

#### Project title: Possible Selves in First Episode Psychosis

Researcher: Rachel Clarke (Trainee Clinical Psychologist)

Supervised by: Dr Jo Hodgekins and Dr Sian Coker (Clinical Psychologists)

Doctoral Programme in Clinical Psychology, School of Medicine and Health  
Sciences,  
University of East Anglia

We would like to invite your child to take part in a research study. Before you decide if you are happy for your child to take part you need to understand why the research is being done and what it would involve for you. Please take time to read the following carefully. Please ask if there is anything that is not clear or if you would like more information. Your child has also been given a participant information sheet.

**Who is conducting the research?** My name is Rachel Clarke and I am a Trainee Clinical Psychologist at the University of East Anglia. This piece of research is part of my training to become a Clinical Psychologist. The research is being supervised by Dr Jo Hodgekins and Dr Sian Coker (Clinical Psychologists).

**What is the research about?** This study aims to gain an understanding of how experiencing a first episode of psychosis impacts on what individuals hope for and fear about the future. These hopes and fears are sometimes described as “possible selves”. This kind of research can help mental health services to understand the needs of people who have experienced psychosis, and to develop interventions and services with a focus on enabling individuals to do the things they want to do with their lives.

**Why has my child been invited to take part in the study?** We are asking people who have experienced a first episode of psychosis, aged 16-35, and who have been involved with an Early Intervention Services to take part in this research study.

**Does my child have to take part?** No. Participation is voluntary. Even if you and your child do agree to take part, your child is able to withdraw from the study at any point following this, without giving a reason, up until the point of information being analysed.

**What does the research involve?** You and your child would have the opportunity to speak with the researcher to ask questions about the study and discuss taking part before you agreed to be involved. If your child would like to take part and you are happy for them to do so, then you will be asked to complete an assent form; your child will also be asked to complete a consent form to say they are happy to take part.

We will arrange a suitable time to complete the research meeting at your home or at your nearest clinic site, whichever you and your child prefer.

The research meeting involves a discussion with your child about their experience of first episode of psychosis and how this has impacted on their hopes and fears for the future. They would be asked to say a little about how they came into contact with mental health services, and briefly about the problems they were experiencing at the time. We would also talk about how the service responded to you and what your main sources of support have been.

There are no right and wrong answers, and your child is free to decline to answer any question they do not feel happy to answer.

The interview will be audio-recorded. After the interview your child will have an opportunity to ask any questions and raise any concerns they may have. They will receive £10 to thank them for participating. I will also ask them if they would like to review a written transcript of their research interview and whether they would like a summary of the research findings when the study is complete.

**What will happen to the information?** I will type out the recording of the interview. This means the information can be looked at in detail with the aim of uncovering common themes that are important in understanding the experiences we have discussed.

The recordings and typed out interviews will be kept at the UEA in a locked storage facility for 5 years after study is complete.

As part of my qualification, I will write up reports of the research, some of which may be published. The reports will include some word for word quotes from the interviews to illustrate themes that have been discussed. Although your child's name will not be included in any reports, the direct nature of the quotes means that complete confidentiality cannot be guaranteed.

Other member of the research team will look at anonymised sections of the information collected from the interview in order to assess the quality of this doctoral research project. This assessment is of me, the researcher, not your child.



**What are the possible disadvantages and risks of my child taking part?** Some people might find talking about their experiences of psychosis upsetting. Every measure will be taken to minimise the risk of distress. If your child becomes upset, they will be given the option to take a break or stop the interview altogether. Following the interview, I will remain available to talk to if necessary and will provide details of where your child can access support.

**What are the potential benefits of my child taking part?** It is hoped that by taking part in this research, your child will be providing valuable information that will help improve the understanding of the experience of first episode psychosis. This is key in providing the best support to others who go through this experience in the future.

**What will happen if my child does not want to carry on with the study?** If, at any point, your child decides they want to withdraw from the study please let me know by contacting me on the email address or phone number given at the end of this information sheet. They will not have to say why they have decided to withdraw. If your child has completed the interview all information relating to this will be destroyed however this will not be possible once the data has been analysed and final report has been written.

**Will my taking part in this study be kept confidential?** A note confirming your child's participation in the study and a copy of the completed consent and assent forms will be added to their clinical notes. Their GP will also be informed of their participation. All other information which is collected about your child during the course of the research will be kept confidential. However, if your child discloses any information which suggests that either they, or someone else, is at risk of harm then I would have to tell someone else. I would always try to discuss this with them first.

**What if there is a problem?** If you have a concern or complaint about any aspect of this study, you may contact me in the first instance. Alternatively you can contact my research supervisor, Dr Jo Hodgekins or Dr Sian Coker (see contact details below). If you remain unhappy and wish to complain formally, you can contact Prof Ken Laidlaw (Director of the UEA Clinical Psychology Course, 01603 593076).

**Who has reviewed the study?**

The study has been reviewed by the Research Ethics Committee (LREC Reference: 15/EE/0188) and the Local Research and Development Department. The study received a favourable ethical opinion and approval.

**Contact Details:**

**Rachel Clarke**

Doctoral Programme in Clinical Psychology,  
Department of Psychological Sciences  
Norwich Medical School  
University of East Anglia  
Norwich Research Park  
NORWICH  
NR4 7TJ

Rachel.yates@uea.ac.uk  
07934107691

**Dr Jo Hodgekins/ Dr Sian Coker**

Doctoral Programme in Clinical Psychology,  
Department of Psychological Sciences  
Norwich Medical School  
University of East Anglia  
Norwich Research Park  
NORWICH  
NR4 7TJ  
j.hodgekins@uea.ac.uk [/s.coker@uea.ac.uk](mailto:s.coker@uea.ac.uk)  
01603 593544

## Appendix H

### Topic guide

#### **Introductions. Go through participant information sheet. Consent.**

How are you feeling about this interview? Do you have any final concerns or questions about the research?

#### **Experience of FEP**

Discussion about development of FEP e.g. when did you first start noticing difficulties? How are things currently?

#### **Exploring possible selves**

Explanation of hoped for and feared possible selves with examples: check understanding.

Clarify 3 hoped for and feared PS now (write these down so can refer to them throughout the interview).

*Follow up if difficulty in doing this: what do you think makes this difficult to think about now/today? What would help?*

#### **“How does experiencing a FEP impact on the descriptions of hoped for, and feared possible selves?”**

Have your possible selves changed at all over the course of experiencing a FEP? If so, how and why? Do you have ideas about what your PS might have been before FEP?

*Follow up prompts: Are there specific factors that positively/negatively impacted on PS, e.g. social support, experience of MH services, therapy?*

*If content of PS is unchanged, what about ‘how likely’ you are to achieve these?*

*Is this something, future hopes and fears, that they have given much thought to? Why/why not?*

#### **“How does experiencing a FEP impact on hoped for, and feared possible selves in relation to mental health difficulties?”**

**If now features:** Are there specific factors that you think have contributed to MH difficulties now being part of your PS? (e.g.’s, if needed, stigma, reaction of others, experiences of services, social support.

*Follow up prompts: Why do you think it is just hoped for PS/or feared PS/or expected that includes MH problems?*

Do you think holding such PS has any impact on you? E.g. influence behaviour, influence mood

**“What are the perceived barriers to achieving hoped for possible selves in those who have experienced a FEP?” and “What has helped people to remain/be optimistic about achieving hoped for possible selves in those who have experienced a FEP?”**

How likely do you believe it is that you will achieve your hoped for possible selves (scale of 1-10)? Is this the same for all hoped for PS?

What do you think is stopping you/will stop you achieving your hoped for PS?

What has/who has helped you to be optimistic about achieving your hoped for PS?

What would have to change/what would help to make it more likely you will achieve your hoped for PS?

### **Final reflections**

I am just wondering how you are feeling now?

Is there anything that you expected me to ask that we have not talked about today? Is there anything that you wanted to say but haven't been asked?

How have you found taking part in this interview?

Are there any questions that you think might be helpful for me to ask to other participants when exploring this area?

**Go through end of study sheet.**

## Appendix I

### Participant consent form



### Participant Consent Form

#### Project title: Possible Selves in First Episode Psychosis

Researcher: Rachel Clarke (Trainee Clinical Psychologist)

Supervised by: Dr Jo Hodgekins and Dr Sian Coker (Clinical Psychologists)

Doctoral Programme in Clinical Psychology, School of Medicine and Health  
Sciences,  
University of East Anglia

#### Please initial the boxes if you agree

1. I confirm that I have read the participant information sheet dated 22/05/15 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary. I am free to withdraw my involvement at any time until the final report is written, without giving a reason. ☐
3. I understand that all data collected will remain confidential and that this will be stored securely. ☐
4. I understand that the researcher may have to speak with members of my clinical team if they have concerns about my own or others safety. ☐
5. I agreed to this interview being audio recorded ☐
6. I agree to parts of my interview being quoted in reports of the research on the basis that any identifying details are removed. ☐

7. I agree to my GP being informed of my participation in the study

☐

8. I agree to take part in this study.

☐

Signed (Participant): .....

Print Name: .....

Date: .....

Signed (Researcher): .....

Print name:.....

Date: ..... .....

## Appendix J

### Parent assent form

#### Parent Assent Form

##### Project title: Possible Selves in First Episode Psychosis

Researcher: Rachel Clarke (Trainee Clinical Psychologist)

Supervised by: Dr Jo Hodgekins and Dr Sian Coker (Clinical Psychologists)

Doctoral Programme in Clinical Psychology, School of Medicine and Health  
Sciences,  
University of East Anglia

#### Please initial the boxes if you agree

1. I agree for my son/daughter to take part in the above research. I have read the participant information sheet dated 22/05/15 (version 2). I understand what my child's role will be in this research and all of my own and my child's questions have been answered to my satisfaction

☐

2. I understand that my child's taking part in this research is voluntary and that they are free to withdraw their involvement at any time until the final report is written, without giving a reason

☐

3. I understand that all data collected will remain confidential and that this will be stored securely

☐

4. I understand that the researcher may have to breach confidentiality if any safety or risk concerns arise

☐

5. I agreed to my child's research interview being audio recorded

☐

6. I agree to parts of my child's interview being quoted in reports of the research on the basis that any identifying details are removed

☐

7. I agree to my child's GP being informed of their participation in the study

☐

8. I agree to let my child to take part in this study

☐

Signed (Parent): .....

Print Name: .....

Name of Participant.....

Date: .....

Signed (Researcher): .....

Print name:.....

Date: ..... .....



## **Appendix K**

### **End of study sheet**

#### **End of study sheet**

#### **Project title: Possible Selves in First Episode Psychosis**

Researcher: Rachel Clarke (Trainee Clinical Psychologist)

Supervised by: Dr Jo Hodgekins and Dr Sian Coker (Clinical Psychologist)

Doctoral Programme in Clinical Psychology, School of Medicine and Health  
Sciences,  
University of East Anglia

Thank you for taking the time to participate in the study.

#### **Interview transcript**

Please delete as appropriate:

- I would/ would not like to review a copy of my interview transcript.
- I would like my transcript to be sent via post to the following  
address.....  
OR I would like to collect my transcript from a member of the clinical team.

#### **Summary of research findings**

Please delete as appropriate

- I would/would not like to receive a written summary of the findings on  
completion of the research.
- I would like the summary to be emailed to the follow  
address.....OR sent via post to the following

address.....OR I would like to collect  
the summary from a member of the clinical team.

### **Reimbursement**

- I confirm that I have received £10 as a thank you for taking part

Signed (Participant): .....

.

Print Name: .....

Date: .....

Signed (Researcher): .....

Print name:.....

Date: ..... .....

## Appendix L

### Example section of coded transcript

	Notes	Transcript	Initial Coding
S1		So that's just really helpful to put some context because obviously people's experiences of coming into the service were very different. So thank you for just kind of going through that. So what we want to try and do now is try to think about...so you currently at the moment...we'll start with kind of your hopes for the future, so what they are at the moment. So for yourself what you'd really hoped to achieve in the future? What we call your hoped for possible selves. And it can be short term or it could be thinking longer term, it's up to you. So for you are they kind of clear, kind of future goals?	
S2	Struck by how clear goals are and how motivated	Yeah there are. Like finding myself a job which is possibly kitchen work and you know, like I think just kitchen portering. Being able to paint in a studio because I went to art school and I do like painting. So to get a studio. I still practice drums and stuff like that and guitar a bit. Yeah, so they're kind of my short term, long terms goals. That's pretty much it, really.	<i>Hoped for possible self- career</i> <i>Hoped for possible self- hobbies</i> <i>Clear ideas about the future</i> <i>Keeping on with hobbies</i> <i>Wanting to be engaged in meaningful activities</i>
S1		Ok... looks as they're kind of career based, aren't they? Which is kind of completely appropriate for someone in your kind of age group. I guess that's what people are thinking about, future career.	
S2	<i>Really feels like he is empowered and knows what he has to do</i>	Yea. Career stuff for sure. That is where my focus in right now. Back where if was before I got ill. Back on track with life I guess...ummm but also to carry on trying to make friends and stuff, but right now I think I've still got friends, but I'm not in a kind of...I'm still trying to learn how to socialise and kind of back to how it used to, which kind of, you know, enjoying socialising. And I started to..... rather than being stressed about it and being depressed about it. Taking steps back to how I used to be. So, yeah.	<i>Career goals are focus</i> <i>Getting life back on track</i> <i>Life disrupted by illness</i> <i>Keen to make new friends</i> <i>Wanting to move forward</i> <i>Motivated</i> <i>Getting life back on track</i> <i>Having to learn how to socialise again</i> <i>Illness had an impact on social life</i>

			<i>Making progress</i>
S1		So that's kind of like a step by step process?	
S2	Very reflective. Learning all the time what is "good"	Yes. Being...yeah, but I have found like working in a kitchen now for XXX....I did two and a half months there. I found it really useful for my mental health. So that's somewhere to go, people to talk to and kind of, you know, it's a new environment where I could socialise. So a job and meeting people. Both were so so helpful for me. Like feeling good and having meaning again. Not just being at home.	<i>Engaged in meaningful activity</i> <i>Getting back to work helped MH</i> <i>Socialising helped MH</i> <i>Engaging in meaningful activity made me feel good</i> <i>Staying at home not helpful</i> <i>Learning what is unhelpful for MH</i> <i>Learning what is helpful for MH</i> <i>MH difficulties led me to withdraw</i>
S1		Yeah, definitely..... So kind of like a sense of meaning and a kind of sense of being and connecting with other people?	
S2		Yeah, def.	
S1		Definitely. Brilliant. And in terms of...so are you living at home now?	
S2		Yeah, with my parents.	
S1		And how is that?	
S2	<p>supported housing.</p> <p>Clear plan for the future broken down into steps.</p> <p>Very similar to peers.</p> <p>Who gave this ideas? Who gave him sense that all this was possible?</p>	<p>Well, I would like to move out. I possibly might move to XXX which is a stepping stone toward towards my own house or flat. So, yeah, that would be ideal. I'd like to have my own house one day, but that's kind of far away. I know that...but...ummm that is ok. I'm still young and none of my friends have their own place yet...so...ummm no rush really.</p>	<i>Hoped for PS- living independently</i> <i>Moving forward in small steps</i> <i>Wanting own house (independence)</i> <i>Able to think and plan for future (housing)</i> <i>Being realistic about future goals</i> <i>Thinking about longer term goals</i> <i>Comparing position with peers</i> <i>Age appropriate goals</i>

S1		Kind of one step at a time?	
S2		Yeah.	
S1		So ...just to summarise, so there are some things about your career and wanting to kind of work in a kitchen and kind of with food and also painting. And kind of carrying on with your hobbies like drumming and either things around continuing to kind of build-up relationships and feel more confident and less stressed about socialising. And maybe thinking about kind of moving out from home as a stepping stone somewhere that's like XXX?	
S2		Yeah.	
S1		Does that sound about right?	
S2		Yeah, that's pretty much where I am, yeah. Good memory (Laughs).	
S1		Brilliant, okay. So the flip side of that is also we all have fears about what might happen and we probably don't think about them as much, but for all of us they're there. What we might call our feared possible selves. And they might be the kind of flip side of our hopes, but equally there might be other things that we fear in the future. So I wondered if you'd thought much about that or were aware of things that you're more afraid of happening for you or that you didn't want to happen in terms of your short or longer term future?	
S2		Yeah. Well I wouldn't want to relapse into like, yeah, the state I was in. So that's pretty much one. I know that. Yeah. Like straightaway when you said that...that...ummm just was the first	<i>Feared PS (relapse)</i> <i>MH difficulties left me in a state</i> <i>MH has improved</i> <i>Fear of relapse came to mind</i> <i>straightaway</i>
S1		Yeah? So of things becoming difficult again in terms of your mental health? So your symptoms becoming as bad as they were?	
S2		Yeah.	
S1		That sounds like a fear. And I think that's, you know, from the interviews that I've done with people, that certainly features a lot. It's very	

		normal to not want to have something happen to you that was so horrible.	
S2	Important to remember that things were really difficult.  Motivated not to go back to that place.	Yeah. Yeah...it is a fear. Everything going pear shaped and all that scary stuff getting worse. I think I've learned my lesson or lessons out of that. So I won't go back to where I was because then I'd have to do it again or be a different person. You know? I'm working hard to move forward so it would feel cruel...umm...I think. Does that make sense.	<i>Relapse is a fear</i> <i>Past experiences (related to MH) were scary</i> <i>Not wanting to go through difficult experiences again</i> <i>Relapsing would change me</i> <i>Rebuilding life after MH difficulties takes effort</i> <i>Learning lessons</i> <i>Moving forward is hard work</i> <i>Wanting to move forward</i>
S1		Yeah. Sure. Okay. So that makes sense. Anything else at all that you kind of are worried about not happening or fear not happening?	
S2		Not really. No. I mean, there's fears inside me, but like they're kinds of things that aren't necessarily real or, you know...so it's kind of like...	<i>My fears don't feel real</i>
S2		Can you say a bit more about that?	
S2		I don't know. Maybe I just don't want to think of fears..ummm..but I guess I feel good about my hopes. They are my focus. Definitely, definitely. I guess if I think about my fears, I might not feel so good about the future	<i>Not wanting to think about fears</i> <i>Feeling optimistic</i> <i>Wanting to focus on hopes</i> <i>Thinking about fears would make me feel less hopeful about future</i>
S1		Okay. I understand that....ummm...	
S2		Yeah. I think maybe it is protection more than anything. I guess I do fear not getting back to myself, yeah. So....job not working and no friends but they are no really real because I don't think they will happen.	<i>Not thinking about future fears is protective</i> <i>Fear not getting back to myself</i> <i>MH problems left me not feeling myself</i> <i>Feared PS (career)</i> <i>Feared PS (relationships)</i> <i>Fears not likely to happen</i> <i>Feeling optimistic about the future</i>
S1		I guess if you feel that they're..umm..your hopes are quite realistic things that will happen then you kind of don't have the same fears. Is that kind of how you feel?	
S2		Yeah, definitely true, definitely true. Yep.	
S1		That's really good.	
S2	Sense that he can just get on with his life.	Best to look up on reality. Be realist. You know?	<i>Future hopes feel realistic</i>

S1		That's really nice to hear. Definitely. So if you skip back to, try, kind of like maybe two years ago and then you think about all that's happened to you, has there been much of a change in what you hope and fear about the future?	
S2	These things come out of the blue. Traumatic and disruptive.	Yeah, definitely. Because I didn't think I was...I didn't have any problems at all, really and then they kind of crept up on me. Or if I did have problems, these were much harder. And then like I had to learn about myself to kind of make them, yeah, easier to cope with. And that's what I found, like, the experience after going, you know, crazy.	<i>Wasn't expecting to have MH difficulties</i> <i>MH difficulties hard to cope with</i> <i>MH difficulties hardest thing I've had to deal with</i> <i>Learning to cope with MH difficulties</i> <i>Learning lessons about myself</i> <i>Learning about myself helped me cope with my difficulties</i> <i>MH difficulties= going crazy</i>
S1		And so if that hadn't happened to you, you said if you hadn't had those difficulties, how do you imagine that your kind of future hopes might look different?	
S2	"pretty much it": something about being manageable or not a big deal?	Well, I would have hopefully carried on my horticulture course. And I'd still be living away from home. That's pretty much it, really. But..well...I guess I would still be hoping for the same kind of stuff generally. Job wise and whatever....ummm yeah. Just the normal stuff. Yeah.	<i>Had to give up course (job) because of MH difficulties</i> <i>Had to move back home because of MH difficulties</i> <i>Life disrupted by illness</i> <i>Categories of hopes not changed</i> <i>Age appropriate future hopes</i> <i>"Normal life" is possible</i> <i>Comparing position with peers</i>
S1		And is there any part of you that wanted to go back to doing anything in horticulture or you kind of decided that that's...	
S2		I think that that wasn't for me. Yeah. It was a lot of remembering Latin names and stuff like that.	
S1		Oh, goodness	
S2		Yeah.	
S1		Yeah. That would test me, definitely.	
S2		It was like, ugh. So I'm not sad about that changing and not doing that anymore. Like....I was...but now I am not. Now I have new goals and I think they are better	<i>Coming to terms with disruption to career</i> <i>Career hopes have changed for the better</i>
S1		Okay. And what about your fears? So again if you hadn't become unwell, do you think...?	

S2	Really saying that fears haven't changed more than how he feels about the situation has changed	I don't know. Not really I guess...like I used to worry about not moving out of my parent's house. Yeah, I think that was probably a fear of mine. You know if I was being spoilt and, you know, it was lovely living with my parents, but it got to a point where we were clashing. So I think I needed to probably move out and have my own life.	<i>Fears before illness about not living independently</i> <i>Age appropriate fears</i> <i>Clashing with parents before illness</i> <i>Hopes about living independently unchanged</i>
S1		So has it been okay moving back there?	
S2		Yeah, completely fine, yeah. I think I've got more respect for them because they just stuck by me...parents and they were really lovely. Yeah, basically.	<i>Positive change in relationship with parents</i> <i>Respecting people who stick by you</i> <i>Family support important</i>
S1		That's nice.	
S2		A lesson there. There has been a change in how we get on as they have just been brilliant....like....brilliant. Just...yeah. Sorry....really supportive so I think we are closer and I have learnt to appreciate them.	<i>Learning lessons</i> <i>Positive change in relationship with parents</i> <i>Valuing support from parents</i>
S1		Yeah, that would be a lesson for all of us to learn.	
S2		Yeah, exactly.	
S1		And so the fear that you now have about relapsing, have you got any sense about how that might impact on you?	
S2	Would he admit if it was? Would he know?  MH something that happened....doesn't mean it will happen again.	No, no. I don't think it does. I'm really quite a positive person, I think and kind of I needed to go outside and to talk to people and I don't want to go back to what I used to be and stay in my room or sleeping or something. So it's kind of get out and socialise so I don't think I would relapse as long as I kind of stick to like being healthy.	<i>Fear of relapse not a barrier</i> <i>Feeling positive</i> <i>Learning what is unhelpful for MH</i> <i>Learning what to do to stay well</i> <i>Socialising has helped MH</i> <i>MH difficulties made me withdraw</i> <i>Feeling that I can stay "well"</i> <i>Relapse not likely</i>
S1		So it sounds a bit like having that fear in a way is a motivator to kind of...to not let it happen. You know what you need to do to not let it happen.	
S2	Empowerment?	Basically, yeah. I don't want it and need to do positive stuff to avoid it. Yeah. So I guess it helps me. It's another lesson learnt. How to stay well and what is positive to do...you know? What is bad for you.	<i>Don't want to relapse</i> <i>I'm in control of my MH</i> <i>Fear of relapse motivator for staying well</i> <i>Fear of relapse helpful</i>



			<i>Learning lessons</i> <i>Learning what to do to stay well</i> <i>Learning what is helpful for MH</i>
S1		That's good. Okay. Let's just check where we are. So....Do you think there are things that have helped you to hold the hopes and fears you do?	
S2	"Learning for myself"...this is my journey of discovery. Being open to learning and trying new things and pushing yourself...?	I think my mum's a really positive person, same for my dad. They're both really positive people, so they kind of, you know, sticking by me and I'm kind of learning that. I get to learn for myself what I need do to socialise and so make everything go smooth, smooth down.	<i>Positive support important</i> <i>Family support important</i> <i>People have stuck by me</i> <i>Learning lessons</i> <i>Taking control</i> <i>Socialising is important for MH</i>
S1		So having their support and it being positive support has been helpful?	
S2		Yeah. Def.	
S1		That's really good. Anything else at all that's helped?	
S2	"nice"...non-judgmental?? Normalising??	Well, voluntary XXX, the people... XXX, all really good, positive people. They're kind of like, you know, they're just really nice as well.	<i>Professional support important</i> <i>Positive support important</i>
S1		Okay.	
S2		Yeah. Something about people around you being positive?	
S1		That kind of...	
S2	"Awesome"	Yeah, and it's like made me realise that I'm not stuck like this, so I cannot be Schizophrenic anymore. So that's pretty awesome.	<i>Not engulfed by illness</i> <i>Realising that recovery is possible</i> <i>Illness is not forever</i> <i>Positive support helped me realise that a future beyond MH difficulties is possible</i> <i>Not defined by MH difficulties</i>
S1		So there is a future beyond this blip in your life?	
S2		Yeah.	
S1		Okay.	
S2	Once thought this would define me? Be like this forever? Sense that views have	Yeah, definitely, yeah. That is so true and so important to learn and I've only learnt that because of people around me being so optimistic and treating me..like...normal..I	<i>Recovery is possible</i> <i>Learning lessons</i> <i>There is a future beyond MH</i>

	changed.	guess. And just talking about a normal future.	<i>difficulties</i> <i>Optimistic support helps you to see future beyond difficulties</i> <i>Important to focus on the future</i> <i>Important for people to treat you like a “normal” person</i> <i>Important for people around you to see past MH difficulties</i> <i>Focus needs to be on more than just “illness”</i>
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## **Appendix M**

### **Excerpts from reflective journal**

#### **Interviews**

After interview one: I was really struck by how positive she felt about her future, particularly considering how traumatic and disruptive her difficulties have been over the last 3 years. A real sense of “life goes on”. I am wondering if this is perhaps because it seems to have been a puerperal psychosis and so the cause and how to prevent in the future is more of a certainty than in other cases? Still interesting to note that relapsing is a very prominent fear but this does not appear to be limiting, more just about learning to be sensible and take care of herself (fear of relapse = important factor in staying well?).

After interview three: Everything about this interview felt very different to the previous ones. We came back to talking about symptoms and medication and everything felt hopeless. I feel really disheartened but I have come out of the other interviews feeling much more positive and inspired. His identity seems to have been eaten up by his ‘illness’ and his future all about getting rid of the ‘illness’. Interesting to note that he is older than the rest of my participants and eluded to a long DUP. I need to be careful not to just dismiss this case as ‘not a typical FEP’ and think about how/if it fits with the rest of my data.

After interview five: So lovely to hear people talk about wanting to work in MH as a consequence of their experiences. I wonder how/whether this is being supported?

After interview six: People have generally been very complimentary about the professional support they have received, particularly about the team at SS having a holistic approach which did not just focus on the psychosis. I think it is probably important to think about the elements of the support that participants refer to rather than the general descriptions of the support.

General reflections on interviews: interesting to think about the people who have NOT been referred to take part in this study. In general, those I have interviewed have been well on the road to recovery and seen their symptoms improve. They are functioning well, seem to have maintained a sense of self as separate from their “illness” and have very “normal” hopes and fears for the future. Is this because of symptoms remission or has this helped symptom remission? Or likely bidirectional.

#### **Coding**

I am trying to keep hold in mind my RQ’s throughout the coding, remembering that this analysis is expanding on and explaining specific points raised in my quantitative analysis. I feel the data show a lot more about recovery from FEP in general so it is difficult not to be drawn into that and widen the scope of the analysis.

It is very difficult to keep track of codes I have already created in order to try and

attach other bits of data to these codes: this feels important as already it feels like there are lots of commonalities across the data. I am also finding that I coding many passages of data with multiple codes.

I am struck again by how different it feels to code interview three and already concerned about this 'fits' with the rest of my data and how I am going to include this in my analysis.

It feels quite satisfying that I am noticing lots of similarities within the interviews (except interview three). However, I am trying to think of each one in isolation at this point so as not restrict my coding.

There seems to be a clear logic to what participants are describing, that they have been able to see beyond the illness and so what most of them hope and fear for the future is very 'normal'. Many of them don't even mention 'mental health' or 'illness' but talk more generally about 'difficulties'. I wonder if that is reflective of how they truly see what has happened or if that is some sort of avoidance. Is it protective? Particularly as many have talked about the stigma of mental health.

## **Analysis**

I have given up using NVivo. I found it really helpful for coding and keeping track of my codes by now I feel the need to be able to play around and sort codes in a more 'hands on' way. I have exported them to word and have then printed them out. I realise this creates difficulties in being able to audit what I have done but it feels much easier to manage and like I can really see and connect with my analysis.

I am finding it incredibly difficult to think about the relationship between codes and the overlap between them. I have decided to go back to the sense I had during coding about there being a 'staged' process of recovery, i.e. that there needs to be some improvement in symptoms to allow people to gradually get back to doing "normal" life tasks and to being considering a "normal" future.

I am trying to keep my research questions at the forefront of my analysis and am thinking carefully about whether codes relate to these or not. I have discarded codes that related to the onset of FEP (e.g. lots of stressors and demands) and those related to "non illness" or longstanding factors (e.g. always had a complicated family life).

I have found it helpful to refer to "good questions to ask yourself in developing themes" (Braun & Clarke, 2013).

I have really struggled with how/whether to include data from participant three, as this feels so different to the others and doesn't fit with the FEP recovery literature but more with the literature on recovery from SMI. In my first 'draft' of themes I decided to include this data as it does say something about the impact on future self of when an individuals becomes engulfed by their illness label. However, on

reviewing these themes and based feedback from supervisors I don't think that is helping to answer my research questions: the data don't fit with my quantitative analysis and I don't know enough context surrounding this participant (such as DUP) as this was not the point of the interview. As such, I am not going to include the hopes and fears information from participant three in my themes but will write a section on this participant as part of the analysis.

### **First draft of themes**

Theme 1: "Getting back to feeling myself"

Subthemes: "Re-engaging in life"  
"Improvement in symptoms"  
"Wanting a "normal" future"

I had this as an initial theme in a first draft. It seem to hang together as a sequential process of symptom improvement allows re-engagement in life which then mean people can think about a normal future. When I have thought about this further though, I don't think this helps to answer any of my research questions and I appear to have just got a bit "lost" in the data and swept up the story they are telling about recovery more generally. I have therefore decided to shelve this theme.

Theme 2: "The possibility of life beyond mental illness"

Subthemes: "I can't see beyond"  
"I can see beyond"

I wasn't convinced by this theme and it was my attempt to include participant 3. Peer and supervisor feedback agreed that this was just two ends of the same concept and not really a theme.

Theme 3: "The lasting impact of my experiences"

Subthemes: "Fear of relapse"  
"My future goals have changed"  
"Lesson learnt"

I am trying to capture how FEP has changed people as this felt like a strong in the data. Thinking about this more it is something about moving forward from here and there is also something about the "lessons learnt" protecting them from "relapse" but then how does "my future goals have changed" fit with this idea?

Theme 4: "The influence of others"

Subthemes: "Professional support"  
"Other people with mental health difficulties "get it""  
"Stigma"  
"Social support- family and friends"

Everyone spoke about the importance of social support and connectedness as being helpful in terms of their MH and then that stigma or fear of stigma had made things difficult (e.g. a barrier to telling people). I wonder if at least the name of this theme needs to say a bit more?

**Second draft of themes:**

Theme 1: "Life beyond psychosis" (or "Belief in Recovery") (7 contribute)  
Subthemes: "Normal" life interrupted" (7 contribute)  
"Hope and optimism" (6 contribute)  
"Focussing on new goals" (5 contribute)

The majority of participants were in a place where they were able to think about picking up on life where they had left it before they developed FEP. They spoke about very normal, realistic, age appropriate hopes and fears about independence, careers and relationships. There was also a sense of feeling very optimistic that hopes would be realised. Most appeared to have a very strong belief that recovery was possible and so of course now they could just get on with life..... Many spoke about the positive influence of their experiences on their hopes for the future, whether this was about giving them focus generally or that they wanted to use their experience to help other who were experiencing MH difficulties. These all feel like a theme about life beyond FEP but I wonder if this is life beyond FEP because they believe recovery is possible and so that is a better name?

Theme 2: "Living with uncertainty" (7 contribute)  
Subthemes: "Possibility of relapse" (7 contribute)  
"Preventing relapse" (6 contribute) (?? Taking responsibility? Self-management? Lifestyle modification?)

Based on my reflections on my first draft of themes, there is something about the fear and uncertainty around future MH difficulties being really apparent (the first PS fear that everyone talked about) but that people have learnt lessons from their experiences that they can use to manage their mental health/lessen the likelihood of a relapse. I am struggling what to call the sub-theme so it captures what I want it to!

Theme 3: "Support and connectedness in promoting recovery" (8 contribute)  
Subthemes: "Professional support" (5 contribute)  
"Other people with mental health difficulties "get it"" (6 contribute)  
"Value of family and friends" (6 contribute)

I have taken "stigma" out of this theme because I felt it didn't really "fit" with the idea that this was about things had promoted recovery. I still wonder if the sub-themes need to capture more about the elements of the support that were helpful? Maybe "connectedness" (not feeling alone) and "understanding and non-

judgement” but I really want to capture the clear idea that contact with other service users was really beneficial.

Theme 4:      “Barriers to recovery” (6 contribute)  
                    “Stigma” (5 contribute)  
                    “Hiding away” (4 contribute)

There is something about things that have held people back and, at some point in their recovery journey, have had an impact on their future possible selves. I have called one sub-theme “hiding away” because I wanted it to capture social isolation and the lack of engagement in meaningful activity (social functioning in general) but I wonder if this could be two sub-themes. I think it might feel a bit “thin” then. I am thinking about whether there is enough data to also add “symptoms” as a subtheme but this is quite difficult. It wasn’t talked about explicitly in lots of interviews because, for most, they weren’t struggling with symptoms at the time and so, I guess, it didn’t feel relevant.

## **Appendix N**

### **Yardley's quality principles (Yardley, 2000).**

- Sensitivity to context - is the analysis and interpretation sensitive to the data, the social context, and the relationships from which it emerged?
  - What was the nature of researcher's involvement?
  - Does the researcher consider how he or she may have specifically influenced participants' actions?
  - Does the researcher consider the balance of power in a situation?
- Completeness of data collection, analysis and interpretation
  - Is the sample adequate to address the research question?
  - Is there transparency and sufficient detail in the author's account of methods used and analytical and interpretive choices? Is every aspect of the data collection process, and the approach to coding and analysing data discussed? Does the author present excerpts from the data so that readers can discern for themselves the patterns identified?
  - Is there coherence across the research question, philosophical perspective, method, and analysis approach?
- Reflexivity- does the researcher reflect on his or her own perspective and the motivations and interests that shaped the research
- Will the research have practical and theoretical utility?



## Appendix O

### Reviewed extract of transcript and initial coding

	Notes	Transcript	Initial Coding
S1		So that's just really helpful to put some context because obviously people's experiences of coming into the service were very different. So thank you for just kind of going through that. So what we want to try and do now is try to think about...so you currently at the moment...we'll start with kind of your hopes for the future, so what they are at the moment. So for yourself what you'd really hoped to achieve in the future? What we call your hoped for possible selves. And it can be short term or it could be thinking longer term, it's up to you. So for you are they kind of clear, kind of future goals?	
S2	Struck by how clear goals are and how motivated	Yeah there are. Like finding myself a job which is possibly kitchen work and you know, like I think just kitchen portering. Being able to paint in a studio because I went to art school and I do like painting. So to get a studio. I still practice drums and stuff like that and guitar a bit. Yeah, so they're kind of my short term, long terms goals. That's pretty much it, really.	<i>Hoped for possible self- career</i> <i>Hoped for possible self- hobbies</i> <i>Linking possible self to past skills / interests?</i> <i>Clear ideas about the future</i> <i>Keeping on with hobbies</i> <i>Wanting to be engaged in meaningful activities</i>
S1		Ok... ..looks as they're kind of career based, aren't they? Which is kind of completely appropriate for someone in your kind of age group. I guess that's what people are thinking about, future career.	
S2	<i>Really feels like he is empowered and knows what he has to do</i>	Yea. Career stuff for sure. That is where my focus in right now. Back where if was before I got ill. Back on track with life I guess....ummm but also to carry on trying to make friends and stuff, but right now I think I've still got friends, but I'm not in a kind of...I'm still trying to learn how to socialise and kind of back to how it used to, which kind of, you know, enjoying socialising. And I started to.... rather than being stressed about it	<i>Career goals are focus</i> <i>Getting life back on track</i> <i>Life disrupted by illness</i> <i>Keen to make new friends</i> <i>Wanting to move forward</i> <i>Motivated</i> <i>Getting life back on track</i> <i>Having to learn how to socialise</i>

		and being depressed about it. Taking steps back to how I used to be. So, yeah.	again Illness had an impact on social life Moving away from mental state associated with illness? Moving back to previous sense of self? Making progress
S1		So that's kind of like a step by step process?	
S2	Very reflective. Learning all the time what is "good"	Yes. Being...yeah, but I have found like working in a kitchen now for XXXXX...I did two and a half months there. I found it really useful for my mental health. So that's somewhere to go, people to talk to and kind of, you know, it's a new environment where I could socialise. So a job and meeting people. Both were so so helpful for me. Like feeling good and having meaning again. Not just being at home.	Engaged in meaningful activity Getting back to work helped MH Socialising helped MH Engaging in meaningful activity made me feel good Staying at home not helpful Learning what is unhelpful for MH Learning what is helpful for MH MH difficulties led me to withdraw
S1		Yeah, definitely..... So kind of like a sense of meaning and a kind of sense of being and connecting with other people?	
S2		Yeah, def.	
S1		Definitely. Brilliant. And in terms of...so are you living at home now?	
S2		Yeah, with my parents.	
S1		And how is that?	
S2	XXX supported housing.  Clear plan for the future broken down into steps.  Very similar to peers.  Who gave this ideas? Who gave him sense that all this was possible?	Well, I would like to move out. I possibly might move to XXX which is a stepping stone toward towards my own house or flat. So, yeah, that would be ideal. I'd like to have my own house one day, but that's kind of far away. I know that...but...ummm that is ok. Im still young and none of my friends have their own place yet...so...ummm no rush really.	Hoped for PS- living independently Moving forward in small steps Wanting own house (independence) Able to think and plan for future (housing) Being realistic about future goals Thinking about longer term goals Comparing position with peers Age appropriate goals

S1		Kind of one step at a time?	
S2		Yeah.	
S1		So ...just to summarise, so there are some things about your career and wanting to kind of work in a kitchen and kind of with food and also painting. And kind of carrying on with your hobbies like drumming and either things around continuing to kind of build-up relationships and feel more confident and less stressed about socialising. And maybe thinking about kind of moving out from home as a stepping stone somewhere that's like XXX?	
S2		Yeah.	
S1		Does that sound about right?	
S2		Yeah, that's pretty much where I am, yeah. Good memory (Laughs).	
S1		Brilliant, okay. So the flip side of that is also we all have fears about what might happen and we probably don't think about them as much, but for all of us they're there. What we might call our feared possible selves. And they might be the kind of flip side of our hopes, but equally there might be other things that we fear in the future. So I wondered if you'd thought much about that or were aware of things that you're more afraid of happening for you or that you didn't want to happen in terms of your short or longer term future?	
S2		Yeah. Well I wouldn't want to relapse into like, yeah, the state I was in. So that's pretty much one. I know that. Yeah. Like straightaway when you said that...that...ummm just was the first	<i>Feared PS (relapse)</i> <i>MH difficulties left me in a state</i> <i>MH has improved</i> <i>Fear of relapse came to mind</i> <i>straightaway</i>
S1		Yeah? So of things becoming difficult again in terms of your mental health? So your symptoms becoming as bad as they were?	
S2		Yeah.	
S1		That sounds like a fear. And I think that's, you know, from the interviews that I've done with people, that certainly features a lot. It's very	

		normal to not want to have something happen to you that was so horrible.	
S2	Important to remember that things were really difficult.  Motivated not to go back to that place.	Yeah. Yeah...it is a fear. Everything going pear shaped and all that scary stuff getting worse. I think I've learned my lesson or lessons out of that. So I won't go back to where I was because then I'd have to do it again or be a different person. You know? I'm working hard to move forward so it would feel cruel...umm...I think. Does that make sense.	<i>Relapse is a fear</i> <i>Past experiences (related to MH) were scary</i> <i>Not wanting to go through difficult experiences again</i> <i>Relapsing would change me</i> <i>Rebuilding life after MH difficulties takes effort</i> <i>Relapse would undo my progress / hard work?</i> <i>Learning lessons</i> <i>Moving forward is hard work</i> <i>Wanting to move forward</i> <i>Relapsing would feel cruel</i>
S1		Yeah. Sure. Okay. So that makes sense. Anything else at all that you kind of are worried about not happening or fear not happening?	
S2		Not really. No. I mean, there's fears inside me, but like they're kinds of things that aren't necessarily real or, you know...so it's kind of like...	<i>My fears don't feel real</i>
S2		Can you say a bit more about that?	
S2		I don't know. Maybe I just don't want to think of fears..ummm..but I guess I feel good about my hopes. They are my focus. Definitely, definitely. I guess if I think about my fears, I might not feel so good about the future	<i>Not wanting to think about fears</i> <i>Feeling optimistic</i> <i>Wanting to focus on hopes</i> <i>Thinking about fears would make me feel less hopeful about future</i>
S1		Okay. I understand that....ummm...	
S2		Yeah. I think maybe it is protection more than anything. I guess I do fear not getting back to myself, yeah. So...job not working and no friends but they are no really real because I don't think they will happen.	<i>Not thinking about future fears is protective</i> <i>Fear not getting back to myself</i> <i>General insight into what helps / hinders progression to goals?</i> <i>MH problems left me not feeling myself</i> <i>Feared PS (career)</i> <i>Feared PS (relationships)</i> <i>Fears not likely to happen</i> <i>Feeling optimistic about the future</i>
S1		I guess if you feel that they're..umm..your hopes are quite realistic things that will happen then you kind of don't have the same fears. Is that kind of how you feel?	

S2		Yeah, definitely true, definitely true. Yep.	
S1		That's really good.	
S2	Sense that he can just get on with his life.	<b>Best to look up on reality.</b> Be realist. You know?	<i>Future hopes feel realistic</i> <b><i>Taking a realistic approach is best?</i></b>
S1		That's really nice to hear. Definitely. So if you skip back to, try, kind of like maybe two years ago and then you think about all that's happened to you, has there been much of a change in what you hope and fear about the future?	
S2	These things come out of the blue. Traumatic and disruptive.	Yeah, definitely. Because I didn't think I was... <b>I didn't have any problems at all, really and then they kind of crept up on me.</b> Or if I did have problems, these were much harder. And then like I had to learn about myself to kind of make them, yeah, easier to cope with. And that's what I found, like, the experience after going, you know, crazy.	<i>Wasn't expecting to have MH difficulties</i> <i>MH difficulties hard to cope with</i> <b><i>MH difficulties / problems were unexpected?</i></b> <i>MH difficulties hardest thing I've had to deal with</i> <i>Learning to cope with MH difficulties</i> <i>Learning lessons about myself</i> <i>Learning about myself helped me cope with my difficulties</i> <i>MH difficulties= going crazy</i>
S1		And so if that hadn't happened to you, you said if you hadn't had those difficulties, how do you imagine that your kind of future hopes might look different?	
S2	"pretty much it": something about being manageable or not a big deal?	Well, I would have hopefully carried on my horticulture course. And I'd still be living away from home. That's pretty much it, really. But..well...I guess I would still be hoping for the same kind of stuff generally. Job wise and whatever....ummm yeah. Just the normal stuff. Yeah.	<i>Had to give up course (job) because of MH difficulties</i> <i>Had to move back home because of MH difficulties</i> <i>Life disrupted by illness</i> <i>Categories of hopes not changed</i> <i>Age appropriate future hopes</i> <i>"Normal life" is possible</i> <i>Comparing position with peers</i>
S1		And is there any part of you that wanted to go back to doing anything in horticulture or you kind of decided that that's...	
S2		I think that that wasn't for me. Yeah. It was a lot of remembering Latin names and stuff like that.	
S1		Oh, goodness	
S2		Yeah.	

S1		Yeah. That would test me, definitely.	
S2		It was like, ugh. So I'm not sad about that changing and not doing that anymore. Like....I was...but now I am not. <b>Now I have new goals and I think they are better</b>	<i>Coming to terms with disruption to career</i> <b>Adjusting goals?</b> <i>Career hopes have changed for the better</i>
S1		Okay. And what about your fears? So again if you hadn't become unwell, do you think...?	
S2	Really saying that fears haven't changed more that how he feels about the situation has changed	I don't know. Not really I guess...like I used to worry about not moving out of my parent's house. Yeah, I think that was probably a fear of mine. You know if I was being spoilt and, you know, it was lovely living with my parents, but it got to a point where we were clashing. So I think I needed to probably move out and have my own life.	<i>Fears before illness about not living independently</i> <i>Age appropriate fears</i> <i>Clashing with parents before illness</i> <i>Hopes about living independently unchanged</i>
S1		So has it been okay moving back there?	
S2		Yeah, completely fine, yeah. I think I've got more respect for them because they just stuck by me...parents and they were really lovely. Yeah, basically.	<i>Positive change in relationship with parents</i> <i>Respecting people who stick by you</i> <i>Family support important</i>
S1		That's nice.	
S2		A lesson there. There has been a change in how we get on as they have just been brilliant.....like.....brilliant. Just...yeah. Sorry....really supportive so I think we are closer and I have learnt to appreciate them.	<i>Learning lessons</i> <i>Positive change in relationship with parents</i> <i>Valuing support from parents</i>
S1		Yeah, that would be a lesson for all of us to learn.	
S2		Yeah, exactly.	
S1		And so the fear that you now have about relapsing, have you got any sense about how that might impact on you?	
S2	Would he admit if it was? Would he know?  MH something that happened....doesn't mean it will happen again.	No, no. I don't think it does. I'm really quite a positive person, I think and kind of <b>I needed to go outside and to talk to people and I don't want to go back to what I used to be and stay in my room or sleeping or something.</b> So it's kind of get out and socialise so I don't think I would relapse as long as I kind of stick to like being healthy.	<i>Fear of relapse not a barrier</i> <i>Feeling positive</i> <i>Learning what is unhelpful for MH</i> <i>Learning what to do to stay well</i> <i>Socialising has helped MH</i> <i>MH difficulties made me withdraw</i> <i>Feeling that I can stay "well"</i> <i>Relapse not likely</i> <b>Pressure on self to keep doing what is helpful?</b> <b>Fear of relapse as motivation to</b>

			keep going?
S1		So it sounds a bit like having that fear in a way is a motivator to kind of...to not let it happen. You know what you need to do to not let it happen.	- Ah ha!
S2	Empowerment?	Basically, yeah. I don't want it and need to do positive stuff to avoid it. Yeah. So I guess it helps me. It's another lesson learnt. How to stay well and what is positive to do...you know? What is bad for you.	<i>Don't want to relapse</i> <i>I'm in control of my MH</i> <i>Fear of relapse motivator for staying well</i> <i>Fear of relapse helpful</i> <i>Learning lessons</i> <i>Learning what to do to stay well</i> <i>Learning what is helpful for MH</i>
S1		That's good. Okay. Let's just check where we are. So....Do you think there are things that have helped you to hold the hopes and fears you do?	
S2	"Learning for myself"...this is my journey of discovery. Being open to learning and trying new things and pushing yourself...?	I think my mum's a really positive person, same for my dad. They're both really positive people, so they kind of, you know, sticking by me and I'm kind of learning that. I get to learn for myself what I need do to socialise and so make everything go smooth, smooth down.	<i>Positive support important</i> <i>Family support important</i> <i>People have stuck by me</i> <i>Learning lessons</i> <i>Taking control</i> <i>Socialising is important for MH</i>
S1		So having their support and it being positive support has been helpful?	
S2		Yeah. Def.	
S1		That's really good. Anything else at all that's helped?	
S2	"nice"...non-judgmental?? Normalising??	Well, XXXX, the people... XXXX, all really good, positive people. They're kind of like, you know, they're just really nice as well.	<i>Professional support important</i> <i>Positive support important</i> <i>Social connections started to build with professionals? – might be a bit of a jump!</i>

S1		Okay.	
S2		Yeah. Something about people around you being positive?	
S1		That kind of...	
S2	"Awesome"	Yeah, and it's like made me realise that I'm not stuck like this, so I cannot be Schizophrenic anymore. So that's pretty awesome.	<i>Not engulfed by illness</i> <i>Realising that recovery is possible</i> <i>Illness is not forever</i> <i>Positive support helped me realise that a future beyond MH difficulties is possible</i> <i>Not defined by MH difficulties</i>
S1		So there is a future beyond this blip in your life?	
S2		Yeah.	
S1		Okay.	
S2	Once thought this would define me? Be like this forever? Sense that views have changed.	Yeah, definitely, yeah. That is so true and so important to learn and I've only learnt that because of people around me being so optimistic and treating me..like...normal..I guess. And just talking about a normal future.	<i>Recovery is possible</i> <i>Learning lessons</i> <i>There is a future beyond MH difficulties</i> <i>Optimistic support helps you to see future beyond difficulties</i> <i>Important to focus on the future</i> <i>Future offers hope to view self as 'normal'? – future change as a way of becoming normal again?</i> <i>Important for people to treat you like a "normal" person</i> <i>Important for people around you to see past MH difficulties</i> <i>Focus needs to be on more than just "illness"</i>



## **Appendix P**

### **Researcher's perspective**

I am a 30-year-old white British female currently training to be a Clinical Psychologist. I carried out the analysis of the quantitative data, conducted the qualitative interviews and analysed the resulting data. Before beginning this project, I had no previous experience of carrying out qualitative or mixed methods research.

Prior to starting training, I had a number of jobs working with people with severe and enduring mental illness, particularly working within a mental health crisis team. This work highlighted the devastating impact mental health problems can have on lives, particularly when people have struggled to access evidence based psychological treatments early in the course of their illness and have been subjected to stigma and pessimistic attitudes regarding recovery. I found this to be a fairly demoralising work environment to work and felt a huge sadness for the people who repeatedly returned in crisis. These experiences also followed many years of caring for a family member with chronic mental health problems where the main focus had been on trying (and often failing) to medicate symptoms away.

Subsequent employment as a research assistant on European project investigating gene-environment interactions in those experiencing a FEP involved working within Early Intervention in Psychosis (EI) teams. This role sparked my interest in working with this population. I was struck by the more optimistic environment in terms of longer-term outcomes than in my previous experiences, the benefits and importance of early intervention and the wider focus of “recovery”, emphasising subjective aspects of this alongside treating symptomatology. All of these reflections underpin my interest and enthusiasm for this research project.

Furthermore, I am aware that my contrasting experiences have led me to have a very positive view of EI teams and a sense that they are beneficial for all those experiencing FEP. In conducting this research it felt important to be mindful that this is an idealist view and that, in reality, people have very different experiences and there are a range of factors that can impact on such and on treatment outcomes.

As this study focuses on possible selves, and how these might be related to or impacted by the experience of an episode of psychosis, it was important to consider my own hoped for and feared possible selves. These are very much shaped by my own life experiences, values and developmental stage. These are detailed below:

*Hoped for possible selves*

- I hope to have a successful career as a Clinical Psychologist
- I hope to have children
- I hope to have more opportunities to travel the world

*Feared possible selves*

- I fear not getting a job when I qualify as a Clinical Psychologist
- I fear life becoming too focused on “work”
- I fear not being able to be a good mother to any children I may have

With this research project it was important to hold in mind that participants may come from a range of backgrounds, having had a variety of life experiences that may mean they value and prioritise different things to myself. This is likely to be reflected in their possible selves.

## Appendix Q

### NHS Ethical approval



#### NRES Committee East of England - Essex

The Old Chapel  
Royal Standard Place  
Nottingham  
NG1 6FS

Telephone: 0115 8839695

12 June 2015

Mrs Rachel Elizabeth Clarke  
Trainee Clinical Psychologist  
Cambridgeshire and Peterborough NHS Foundation Trust  
Doctoral Programme in Clinical Psychology  
2.30, Elizabeth Fry Building, School of Medicine,  
University of East Anglia, Norwich, Norfolk  
NR4 7TJ

Dear Mrs Clarke

Study title:	Possible selves in first episode psychosis. A mixed methods study.
REC reference:	15/EE/0188
Protocol number:	NA
IRAS project ID:	168776

Thank you for your letter of 1 June 2015, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Miss Helen Poole, [NRESCommittee.EastofEngland-Essex@nhs.net](mailto:NRESCommittee.EastofEngland-Essex@nhs.net)

Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

#### Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

### Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations*

### Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact [hra.studyregistration@nhs.net](mailto:hra.studyregistration@nhs.net). The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

### **Ethical review of research sites**

#### **NHS sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management

permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

### Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Covering letter on headed paper [Ethics amendments]	v1	22 May 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance RC 16.04.15]	v1	16 April 2015
GP/consultant information sheets or letters [Leaflet for professionals]	v2	22 May 2015
GP/consultant information sheets or letters [GP letter]	v1	22 May 2015
Interview schedules or topic guides for participants [Provisional Topic Guide v1 24.01.15]	v1	24 January 2015
IRAS Checklist XML [Checklist_28052015]		28 May 2015
Other [Secondary Supervisor CV]	v1	
Other [Amendments to thesis proposal v1 24.01.15]	v1	22 January 2015
Other [Verification of Transcript Form v1 24.01.15]	v1	24 January 2015
Other [End of study sheet v1 24.01.15]	v2	22 May 2015
Other [Data set info]	v1	23 April 2015
Other [Review process]	v1	22 May 2015
Participant consent form [Participant Consent Form v1 24.01.15]	v2	22 May 2015
Participant consent form [Parent Consent Form v1 24.01.15]	v2	22 May 2015
Participant information sheet (PIS) [Participant Information sheet v1 24.01.15]	v2	22 May 2015
Participant information sheet (PIS) [Parent Information Sheet v1 24.01.15]	v2	22 May 2015
REC Application Form [REC_Form_17042015]		15 April 2015
Referee's report or other scientific critique report [Internal review marking comments 01.12.14]	v1	25 November 2014
Research protocol or project proposal [Thesis Proposal v1 24.01.15]	v2	22 May 2015
Summary CV for Chief Investigator (CI) [Rachel Clarke CV]	v1	23 December 2014
Summary CV for supervisor (student research) [CV Joanne Hodgekins v1 24.01.15]	v1	

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

### After ethical review

#### Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

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

#### **User Feedback**

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

#### **HRA Training**

We are pleased to welcome researchers and R&D staff at our training days – see details at

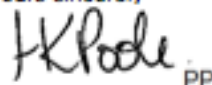
<http://www.hra.nhs.uk/hra-training/>

**15/EE/0188**

**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely



**Dr Alan Lamont**  
**Chair**

Email: [NRESCCommittee.EastofEngland-Essex@nhs.net](mailto:NRESCCommittee.EastofEngland-Essex@nhs.net)

*Enclosures:* "After ethical review – guidance for researchers"

*Copy to:* Mrs Sue Steel  
Dr Bonnie Teague, NHS



## Appendix R

### R and D approval

Norfolk and Suffolk   
NHS Foundation Trust

Research and Development  
The Knowledge Centre  
Hellesdon Hospital  
Drayton High Road  
Norwich  
NR6 5BE

Telephone 01603 421255  
E mail: [RDoffice@mailbox@nsth.nhs.uk](mailto:RDoffice@mailbox@nsth.nhs.uk)

Mrs Rachel Clarke  
Department of Psychological Sciences  
Norwich Medical School  
University of East Anglia  
Norwich  
NR4 7TJ

12<sup>th</sup> June 2015

Dear Mrs Clarke,

**Re: RD #15 168776: Possible selves in first episode psychosis. A mixed methods study.**

Thank you for submitting the above project for local research governance approval. I am pleased to inform you that your project has been given full approval and you may begin your research at the following site:

- Norfolk & Suffolk NHS Foundation Trust

I have enclosed two copies of the Standard Terms and Conditions of Approval. Please sign both copies returning one copy to the Research and Development office, at the above address, and keeping the other in your study file. Failure to return the standard terms and conditions may affect the conditions of approval. Under the agreed Standard Terms and Conditions of Approval you must inform the R&D department of any proposed changes to this study and submit annual progress reports to the R&D department.

Any researcher(s) whose substantive employer is not the Norfolk & Suffolk NHS Foundation Trust must have a Letter of Access or Honorary Research contract and evidence of Good Clinical Practice (GCP) training before coming on site to conduct their research in this project. Please note that you cannot take part in this study until you have this documentation. If a Letter of Access / Honorary Research Contract has not been issued – please contact us immediately.

If you have any queries regarding this or any other project, please contact, Tom Rhodes, Senior Research Facilitator, at the above address.

The reference number for this study is: **RD #15 168776**, and this should be quoted on all correspondence.

Yours sincerely,



Bonnie Teague  
Research Manager



Chair: Gary Page  
Chief Executive: Michael Scott  
Trust Headquarters: Hellesdon Hospital,  
Drayton High Road, Norwich, NR6 5BE  
Tel: 01603 421421 Fax: 01603 421440 [www.nsth.nhs.uk](http://www.nsth.nhs.uk)



Your research governance approval is valid providing you comply with the conditions set out below:

1. You commence your research within one year of the date of this letter. If you do not begin your work within this time, you will be required to resubmit your application.
2. You notify the Research and Development Office should you deviate or make changes to the approved documents.
3. You alert the Research and Development Office by contacting the address above, if significant developments occur as the study progresses, whether in relations to the safety of individuals or to scientific direction.
4. You complete and return the standard annual self-report study monitoring form when requested to do so at the end of each financial year. Failure to do this will result in the suspension of research governance approval.
5. You comply fully with the Department of Health Research Governance Framework and Trust Research Policies, and in particular that you ensure that you are aware of and fully discharge your responsibilities in respect to Data Protection, Health and Safety, financial probity, ethics and scientific quality. You should refer in particular to Sections 3.5 and 3.6 of the Research Governance Framework.
6. You ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice, Data Protection Act and Human Rights Act. Unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.
7. **UKCRN Portfolio Studies only:** You will make local Trust research team members aware that it is expected that the "first participant, first visit" date should be within 70 days of the full submission for Trust Research Governance Approval, and this date must be reported to the Research and Development office using the email address above. Delay to recruitment due to study-wide developments must be reported to the Trust as soon as possible.
8. **UKCRN Portfolio Studies only:** You will report and upload Trust recruitment to the UKCRN portfolio accurately and in a timely manner, and will provide recruitment figures to the Trust upon request.

#### Version Control

Document	Version	Date
Leaflet for professionals	2	22.05.15
GP Letter	1	22.05.15
Topic Guide	1	24.01.15
End of study sheet	2	22.05.15
Consent Form: Participant	2	22.05.15
Consent Form: Parent	2	22.05.15
Participant Information Sheet: Participant	2	22.05.15
Participant Information Sheet: Parent	2	22.05.15
Protocol	2	22.05.15



Chair: Gary Page  
 Chief Executive: Michael Scott  
 Trust Headquarters: Hellesdon Hospital,  
 Drayton High Road, Norwich, NR6 5BE  
 Tel: 01603 421421 Fax: 01603 421440 www.nstt.nhs.uk





## **Appendix S**

### **Ethical considerations for phase two**

#### **Informed Consent**

Prior to data collection, written informed consent was gained from all participants using a consent form (Appendix I). Participants were made aware that consent and participation was voluntary, that they were free to withdraw from the study, without giving a reason, up until the qualitative data had been analysed and that withdrawing would have no repercussions on any current treatment. As outlined in the inclusion criteria, the capacity of potential participants to consent to take part was judged by the clinician responsible for their care when referring to the study: if there was any doubt over this then the individual was not invited to participate.

If any participants aged 16-18 had been referred, assent from a parent or guardian would have been sought in addition to the consent of the young person (Appendix J). The parent or guardian would also have been provided with an information sheet about their child's participation in the study (Appendix G). If this additional assent could not have been sought, it would not have prevented participants in this age group from taking part.

#### **Confidentiality**

A note simply confirming their participation was added to participants' clinical notes. Further information about participation in the study was only passed to the clinical team if it became apparent during the interview that a participant may have been at-risk of causing harm to themselves or others or disclosed details of activities that raised concerns about the welfare or safety of children or vulnerable

adults. Participants were made aware of this via the participant information sheet.

Any breach in confidentiality would have been discussed with participants first unless it was deemed that doing so would increase the risk.

To preserve anonymity participants were given an identification number to be used on their transcripts. All data including paper documents, electronic documents and recordings were stored securely on password protected encrypted memory sticks or in a locked filing cabinet on University premises. Any documentation containing personal details (e.g. consent forms) was stored separately. All original data will be stored in accordance with ethical approval for five years following completion of the study, in accordance with the Data Protection Act (1998).

## Appendix T

**Selected associated codes for each sub- theme, along with the number of participants that contributed to each theme and sub-theme**

“Belief in recovery” (7 participants)		
“Normal” life interrupted (7 participants)	Hope and optimism (7 participants)	Focusing on new goals (6 participants)
Normal life has just been interrupted	Optimistic about future	New career goals as a result of my experiences
There is a future beyond my MH difficulties	Feeling motivated to get on with life	New interest in working in mental health
Mental illness doesn’t define me	Remaining hopeful despite symptoms	Wanting to use experiences of mental health to help others
Having age appropriate hopes and fears	Focused on my hopes	Experiences given me focus
Hoping to get married	Fears not likely to happen	Harder to be ambitious
Hoping to learn to drive	Feeling motivated to get on with life	Developing new interests
Hoping to get a job	Normal life is possible	

“Living with uncertainty” (8 participants)	
Possibility of relapse (8 participants)	Learning what I can to do stay well (5 participants)
Fear of relapse not a barrier	Experiences made me grow up
Fear of relapse will always be there	Learning to be more self-aware
Worried my symptoms will get worse again	Learning to look after myself
Uncertainty about my mental health	Learnt how to stay well
The uncertainty of relapse is difficult	Learning when I need support from others
Concerns about relapse prominent	Doing less drugs
Relapse would feel cruel	Learning about my limits is important
Relapse possible but not likely	I’m more sensible now
Hoping to stay well	Gained more respect for life
	If I push myself I might get ill again

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“Potential barriers to recovery” (7 participants)	
Hiding away (5 participants)	Stigma (6 participants)
Staying at home not helpful	Worried how others might respond to me telling them I have mental health difficulties
Socialising helped my mental health	Worry about discrimination
Getting back to work helpful	Worried about being judged
Hiding away if the worse thing you can do	Discrimination as barrier to moving forward
	Facing stigma
	Stigma prevented me telling my family about my difficulties

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“Connectedness and social support in promoting recovery” (6 participants)		
Others believing in me and my recovery (5 participants)	Feeling understood (6 participants)	Having people I can rely on (5 participants)
Professionals holding hope	Difficult for people without mental health problems to understand	Support from friends has been important
Professionals offering encouragement	Other people with mental health problems “get it”	Consistent professional support
Family remained positive	Important not to feel alone	Maintaining friendships important
Professionals remaining positive		
Professionals looked beyond my illness		

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