Understanding Adaptation to First-Episode Psychosis: The Relevance of Trauma and Posttraumatic Growth

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Abstract

This paper examines recovery from first-episode psychosis in terms of models of trauma and posttraumatic growth. Two first-episode psychosis patients (male and female aged 22 and 25 years respectively) who had a diagnosis of Bipolar I Disorder and had been hospitalised at a public mental health inpatient unit and their family members participated. Qualitative data from in-depth interviews suggests that recovery from first-episode psychosis can be conceptualised within a trauma framework. The two first-episode psychosis participants identified their experiences as traumatic and acknowledged elements of posttraumatic growth. The case studies also point to individual differences and needs and demonstrate important areas for research and early intervention practices. Research is also needed to understand the broader complexities of growth and how it relates to the experience of first-
Psychosis is an experience that can involve a significant distortion in the perception of reality and impairment in the capacity to reason, speak, respond, and behave appropriately. Psychotic symptoms include delusions, hallucinations, or disorganised behaviour, speech and thought. Psychosis is not a diagnosis itself but it is associated with a number of disorders such as, schizophrenia, bipolar, and schizoaffective disorder (Fauman, 2002). Any episode of psychosis has been considered one of the most severe events a person can be subjected to (Lundy, 1992) and is highly distressing. However, it is the first episode of psychosis (FEP) people experience that is particularly dramatic because it usually occurs at a critical age, that is, when the young adult is consolidating their identity, and forming significant relationships outside the family. A psychotic episode can shatter this process, impacting on the person’s sense of self, experience of life and the world, and relationships (Riedesser, 2004). Thus, it is appropriate to consider FEP and adjustment to this event within a trauma framework (Jackson & Ikbal, 2000).

In 1977 Jeffries proposed the idea that “going crazy is a traumatic experience” (p. 199). Although professionals have been aware of the social and psychological trauma of psychosis, interest in this area has been neglected until recently (Harrison & Fowler, 2004; Riedesser, 2004). There has been an increased recognition of the traumatic aspects of psychosis in first person accounts (e.g., Bayley, 1996) and clinical case studies (e.g., Shaner & Eth, 1989). Additionally, some empirical research has focused on the traumatic aspects of psychosis and the presence of Posttraumatic Stress Disorder (PTSD) amongst people who have experienced psychosis (e.g., Shaw, McFarlane, Bookless, & Air, 2002). However, there is little empirical research on the stressful impact of psychosis (Morrison, Frame & Larkin, 2003) and how people adjust to its onset (Jackson & Iqbal, 2000) even though understanding adaptation to FEP may influence the management of this event. Early intervention is considered crucial for FEP because it can influence the course of the illness, prevent the development of an enduring mental illness (Birchwood, 2000) and reduce the impact of co-morbid conditions such as post-psychotic depression.

The Traumatic Experience of Psychosis

Jeffries (1977) articulated that psychosis is a traumatic event that can lead to “traumatic neurosis” (p. 199). However, a factor that has precluded the consideration of traumatic responses in FEP is the restriction of the PTSD diagnosis. Traditionally, theories have suggested that stressors leading to PTSD are external rather than internal (Lundy, 1992). The ability of psychosis to fulfil this criterion depends on the allowance that threat may be subjectively as well as objectively experienced (Morrison et al., 2003).

Exploring the traumatic aspects of psychosis have led researchers to consider the impact of treatment experiences (e.g., Meyer, Taiminen, Vuori, Aijala, & Helenius, 1999) and the symptoms (e.g. Shaw et al., 2002) themselves as possible sources of trauma. For instance, Shaw, McFarlane, & Bookless (1997) discovered that people experiencing psychosis and PTSD symptoms rated involuntary status, treatment setting, and number of admissions as the most distressing aspects of being unwell. In particular, Shaw et al. revealed that treatment experiences involving loss of control were related to intrusive thoughts. McGorry et al (1991) discovered that some participants reported recurrent nightmares involving seclusion or forced sedation. Similarly, Meyer et al. found that coercive measures were traumatising and potentially related to PTSD symptoms. Yet, in several studies (e.g., Priebe, Broker, & Gunkel, 1998; Shaw et al., 2002; & McGorry et al.) there was no significant relationship between PTSD symptoms and treatment experiences. Nevertheless, although treatment is not clearly associated with PTSD symptoms, research has demonstrated that these experiences are highly stressful and that for some people the experience stays
with them.

Positive symptoms can constitute a traumatic event as they often involve severe perceptions of threat. Shaner and Eth (1989) documented the subjective experience of a 32 year-old man with schizophrenia and co-morbid PTSD. The participant’s symptoms were experienced as threats of torture, death, and public ridicule. Post psychosis he continued to think about what he endured, worried that it would recommence, and had nightmares in which the traumatic experiences returned. According to Shaner and Eth, he became hypervigilant, avoided stimuli associated with the trauma and appeared numb.

Shaw et al. (1997, 2002) discovered that passivity phenomena, persecutory delusions and visual hallucinations were particularly distressing. Although there was not a clear association between positive symptoms and PTSD symptoms, these symptoms were present with greater frequency in participants who were experiencing PTSD symptomatology and were rated as more distressing and the cause of more intrusive memories in this group. Meyer et al. (1999) found a clear association between PTSD symptoms and psychotic symptoms. Their results showed that a high score on the Positive and Negative Syndrome Scale 8 weeks after an acute admission was a significant risk factor for developing PTSD. Despite these findings, empirical research on the relationship between positive symptoms and distress has been neglected.

Negative symptoms of psychosis may also be a response to trauma (Stampfer, 1990). Harrison and Fowler (2004) examined the relationship between negative symptoms and avoidance of traumatic reactions to psychosis as measured by deficits in autobiographical memory. They discovered that negative symptoms were significantly related to avoidance of traumatic memories of psychosis and lack of detail in autobiographical recall. Another study, found no relationship between PTSD symptomatology and negative symptoms. Yet, the group with PTSD symptoms showed an increase in negative symptoms between the two follow-up periods, whereas the non-PTSD group did not. These studies highlight that the relationship between negative symptoms and the traumatic impact of psychosis requires further exploration.

The equivocal results of research exploring the relationship between psychosis and PTSD symptoms gives credibility to the idea of individual disparity (Jackson & Iqbal, 2000). Research has demonstrated that individual appraisals might be more important than objective events (Jackson, Knott, Skeate, & Birchwood, 2004). For instance, a study that looked at rape, an objective traumatic event, found that victims who perceive the assault as life threatening were more likely to develop PTSD than those who did not (Kilpatrick, Saunders & Amick-McMullan, 1989). McGorry et al. (1991) concluded from their findings that it could be the subjective level of distress from psychosis rather than the event that leads to PTSD symptoms. Also, it is possible that psychosis could be traumatic without meeting the criteria for PTSD. Indeed, Shaw et al. (2002) found that psychological distress of an acute psychotic episode was not restricted to those participants who experienced PTSD symptoms. Jackson et al. invited further research on subjective factors that personalise trauma during a psychotic episode.

Recovery from Psychosis

One way of understanding psychosis is to draw upon ideas of how people integrate and adapt to this traumatic experience. The medical model assumes that recovery refers to a remission of symptoms (Kelly & Gamble, 2005). However, Kelly and Gamble suggest that it also involves an experience of personal growth, the development of new meaning and purpose, and redefining identity.

Models have been put forward to explain the process of recovery from psychosis. As long ago as 1920, Mayer-Gross proposed a classification of the various ways a person may react to an acute psychotic experience. He distinguished four modes: denial of the future (despair); denial of the experience itself (exclusion); creation of a ‘new life’ after the illness; and ‘melting’ of the illness into a continuous set of ‘life values.’ He claimed the last of these were the most useful (as cited in Jeffries, 1977, pp. 200-201). Andresen, Oades, and Caputi (2003) presented a five-stage model of recovery. They identified four key
processes of recovery: finding hope, re-establishment of identity, finding meaning in life, and taking responsibility for recovery. Five stages were suggested: moratorium, awareness, preparation, rebuilding, and growth. Andresen et al. defined psychological recovery as a development of hope and self-determination, which leads to a meaningful life and positive sense of self whether or not mental illness is present.

McGlashan, Docherty and Siris (1976) argued that people recovering from psychosis will use one of two recovery styles: sealing-over or integration. They explain that the sealing-over style is evident in people who prefer not to think about their psychotic experience during recovery. These people are thought to isolate their psychotic experience because they view it as incompatible with their life. In contrast, McGlashan et al. assert that people who adopt an integration recovery style are aware of the continuity of themselves before, during and after their psychosis, take responsibility for their psychotic experience and are aware of both the pleasure and pain of it. The integrator is interested in their psychosis and wishes place into some coherent perspective. Therefore, the integration of new material during the recovery journey leads to new representations of the self and world, which can lead to successful adjustment (Jackson & Iqbal, 2000).

These notions of recovery reflect aspects of posttraumatic growth, a contemporary model from the trauma literature. Posttraumatic growth is a relatively new concept that considers the positive experiences that can come out of traumatic events as well as the parallel pain and anguish trauma can cause (Tedeschi & Calhoun, 2004). Posttraumatic growth does not occur as a direct result of trauma. Instead, it refers to the “positive psychological change experienced as a result of the struggle with highly challenging life circumstances” (Tedeschi & Calhoun, p.1). Tedeschi and Calhoun explain that posttraumatic growth is not a return to the level of functioning prior to the trauma but it is an experience of improvement. They postulated five domains of posttraumatic growth: a greater appreciation of life and changed sense of priorities; warmer, more intimate relationships with others; a greater sense of personal strength; recognition of new possibilities or paths for one’s life; and spiritual development. Posttraumatic growth is considered to be an outcome of the experience rather than a strategy for coping with the stress the trauma can cause (Calhoun & Tedeschi, 1998).

Even though the relationship between psychosis and posttraumatic growth has not been investigated, authors have indicated that people who have experienced psychosis can have experiences that are consistent with the notion of growth. For instance, Barker, Lavender and Morant (2001) explored the narratives created by clients and family members to explain the process of developing schizophrenia. Family members and clients raised the issues of self-development and identity. Clients saw this as a positive aspect of developing schizophrenia. A major theme was that the experience of being unwell enabled participants to be more “themselves.” Similarly, Reeves (2000) argues that people with psychosis are able to change their perceptions about themselves and the world to something more positive. Nevertheless, Reeves highlights that although growth through adverse experiences has always existed in human society, it has not been recognised or fostered amongst people with mental illnesses.

Williams and Collins (1999) argue that one of the difficulties in capturing the experience of mental illness comes from an over reliance on quantitative methods to explore qualitative ideas. There is a severe lack of empirical research that also recognises the subjective experience of people who have had a psychotic episode. A search of the literature only found four empirical studies (Jackson et al., 2004; Meyer et al., 1999; Shaw et al., 1997; Shaw et al., 2002) that used semi-structured interviews and one study (Pribe, et al., 1998) employed standardised interviews. McGorry et al. (1991) suggest from their results that more intensive interview-based methods should be employed to better understand the subjective stress psychosis can cause and how people adapt to this experience. Thus, rather than reducing people’s experiences to statistics (Koivisto, Janhonen, & Vaisanen, 2002) and assuming what experiencing psychosis is like, it is important to maintain a “meaningful dialogue” (Williams & Collins, p. 1) with people with psychosis so that they can inform us of their experiences in their own words.

This study investigated the recovery process in two people who had experienced a first occurrence of psychosis. The aim was to explore the utility of a trauma framework/perspective in understanding
recovery from FEP, and to see whether constructs pertinent to trauma and posttraumatic growth emerged in people’s accounts of recovery. Three research questions guided the research:

1. Can FEP be considered a traumatic experience and if so, what are the traumatic aspects of this event?
2. Do FEP clients experience posttraumatic growth? If so, how is growth experienced and what is their understanding of this transformation?
3. What is the recovery pattern of FEP overtime in relation to the recovery styles sealing-over and integration? Can their patterns of recovery be conceptualised within the trauma and posttraumatic growth framework?

Method

**Inclusion Criteria**
FEP participants were recruited if they had (1) recently experienced an acute FEP as defined by “the first treated episode of psychosis experienced by an individual in their lifetime” (National Early Psychosis Project Clinical Guidelines Working Party, 1998); (2) had significant psychotic symptoms that required acute psychiatric intervention (hospitalisation and/or Crisis Assessment and Treatment Team involvement); (3) had a primary diagnosis of a psychotic illness conforming to the DSM-IV-TR (American Psychiatric Association, 2000) criteria and confirmed by the participants’ treating team and file notes; (3) had now reached complete, or near complete, remission and were at a point where they were deemed able to give informed consent and participate in the study as determined by their treating team; (4) and had a family member that was willing to be involved in the study and could give informed consent.

**Participants**
Two participants, aged 22 (male) and 25 (female) years, were recruited from Alfred Psychiatric Outpatient Services in Melbourne, Australia. Both participants had a diagnosis of Bipolar I Disorder, with psychotic features. It was their first episode of psychosis according to the Australian Clinical Guidelines for Early Psychosis, which defines FEP as “the first treated episode of psychosis experienced by an individual in their lifetime.” Their mothers were also recruited as participants in the study.

**Procedure**
Ethics approval was obtained from the Alfred Hospital and Swinburne University of Technology’s Human Research Ethics Committee. The study was presented to two outpatient clinical teams and advertised via brochures and handouts. FEP participants were identified through the hospital’s database and discussions with clinicians. Clinician’s provided approval for their clients to be approached about the research. Initially the study was raised with potential FEP participants to gauge their interest and provide them with participant information and consent forms and brochures. Upon expressed interest to participate, informed consent was completed. FEP participants were asked to nominate which family member they would like to participate in the study. Family members were contacted via phone with the permission of FEP participants and a participant information and consent form and brochure was sent to them in the mail. Family members then met with researchers to complete consent form.

The research was prospective and employed both qualitative and quantitative data collection. There were two stages to data collection. FEP participants were seen at approximately 5 months (stage 1) and approximately 8 months (stage 2) after their acute psychotic episode. At both stage 1 and 2, FEP participants were asked to participate in a 2 semi-structured interviews and complete 3 self-report measures. Data collection with psychosis participants took approximately 2.5 hours. At stage 2 a family member was interviewed. Sessions with family members took approximately 1.5 hours. Demographics and detailed information about participants’ mental health issues were collected from files and clinicians. Data collection took place at either the FEP participants’ primary clinical support service or at an office at the Alfred Psychiatry Research Centre. Participants completed these assessments as part of a broader project. This papers main focus is on the interview data.
Materials

The Recovery Style Questionnaire (RSQ)
The RSQ was developed by Drayton, Birchwood, and Trower (1998) to measure recovery style in people with psychosis. The questionnaire is based on McGlashan, Levy & Carpenter's (1975) interview measure of recovery styles. The RSQ is a 39-item self-report tool, which requires the participant to either agree or disagree with the statements. The questionnaire has 13 subscales (e.g., curiosity, education, and optimism). Participants’ responses to items are assigned either a score of 1 or 2. These scores are then added to obtain a score for each of the 13 subscales. The participants' response to each of the 13 scale concepts is assigned to either an integration (score = 5 or 6) or sealing over category (score = 3 or 4). An overall recovery style score is then obtained. Four recovery styles can be classified: integration; mixed picture in which integration predominates; mixed picture in which sealing over predominates; and sealing over. This paper focuses on the total recovery style scores. The RSQ has strong criterion-related validity ($r= .92$), re-test reliability (Spearman $r=.81$). Internal reliability was investigated using Cronbach’s alpha coefficient and was also found to be acceptable ($\alpha=.73$) (Drayton et al.).

The Positive and Negative Syndrome Scale (PANSS)
The PANSS, a semi-structured interview, was developed by Kay, Fiszbein, and Opler (1987) and is a measure of severity and quality of psychotic symptoms. The PANSS ratings are based on all information pertaining to the previous week and the measure can be used repeatedly for longitudinal assessment of symptoms. In this study, information used to rate the PANSS items came from the interview itself, other forms of data collection used in the broader study, file notes, and discussions with clinical staff. Of the 30-items, 7 relate to a positive scale (e.g., delusions, conceptual disorganisation, & hallucinatory behaviour), 7 items are included in the negative scale (e.g., blunted affect, passive/apathetic social withdrawal, & stereotyped thinking), and the general psychopathology scale (e.g., anxiety, guilt feelings, & poor impulse control) includes 16 items. Each item on the PANSS is accompanied by a definition as well as anchoring criteria for the 7 rating points (1 = absent to 7 = extreme). The PANSS is scored by adding the ratings across items. A bipolar composite scale is calculated by subtracting the negative from positive score and can range between -42 to +42 and determines which syndrome predominates (Kay et al.).

The PANSS is a well established measure. The negative, positive, and general psychopathology scales have high internal consistency ($\alpha=.83$, $\alpha=.73$, & $\alpha=.79$ respectively) and the positive and negative scales correlated strongly with the composite scale. The positive, negative, composite, and general psychopathology scales, respectively, re-test Pearson correlations were .80, .68, .66, and .60 (Kay et al., 1987). Discriminant, convergent and construct validity was present.

Interview protocol
Semi-structured interviews were developed for FEP participants. They were designed to be open-ended to invite the interviewee to engage in a narrative about their experiences of being unwell. A semi-structured interview was also developed for family members to enable a richer understanding of the experiences and changes their family member may have gone through since being unwell. Participants were informed at the beginning of the interview that the researcher wished to hear their viewpoints in order to develop a greater understanding of the experiences people have when they first become unwell and the changes they may go through since being unwell.

The principal concern was to understand peoples’ recovery process from two particular notions: trauma and posttraumatic growth. Therefore, the interviews allowed participants to discuss both positive and negative aspects of being unwell. The interview was broken into two broad sections akin to the notions of trauma and posttraumatic growth. The first half of the interview was spent exploring the experiences of FEP participants’ psychotic episode and treatment. Inquiry about meaning and change as a result of FEP participants’ experiences of being unwell then followed.

Reflective listening techniques, ‘checking-in’ and clarification were used to ensure that the understanding of the participants’ responses was accurate. An empathic listening style was utilised in order to engage the
participants. Both a broader account of participants’ experiences and specific examples were elicited. At the end of the interviews participants were debriefed. Participants found it to be a helpful experience, and some commented on the importance of recognising positive outcomes of the psychotic episode. No one reported an adverse reaction. All interviews were tape recorded and transcribed and interview responses were coded. Initially, open coding was employed in order to identify thematic units and idea concepts. Focused coding was then used to find notions of growth and trauma while looking for, and allowing themes to emerge from the interview data. Researchers then looked at what themes and ideas were both common and individual to the participants and related these to the pre-existing dimensions of trauma and growth.

Results

Case study analyses were employed to effectively understand individual experiences of FEP within the broader notion of recovery from two theoretical perspectives: trauma and posttraumatic growth. The case study design type was descriptive so as to employ the data to understand this orientation. Analyses involved gathering data from file notes, the RSQ and PANSS, and in-depth interviews in order to present rich and detailed information about the participants. Participant names have been changed to preserve confidentiality.

Case Study 1. Tom

Tom, aged 22 years, was diagnosed with Bipolar I Disorder, with psychotic features. He presented with ideas of reference, grandiose, bizarre, non-bizarre, and paranoid delusions, visual and auditory (command) hallucinations, and disorganised speech and behaviour. Tom became unwell when he was living and studying interstate. While unwell he was charged with criminal acts and was hospitalised in a psychiatric forensic hospital for approximately 3.5 months. Police were involved in his admission. Tom allegedly experienced an incident of physical assault from another person who had been arrested when he was detained by police. His other hospital experiences included: restraint, sedation, seclusion, and a high dependency unit admission. At 5 and 8 months Tom demonstrated very few psychotic related symptoms (overall PANSS scores = 36 and 38 respectively). However, negative symptomatology predominated, with a slight increase in negative symptoms at session two (stage 1 = 9 and stage 2 =12). Even so, ratings on negative symptoms were very low. Tom had maintained his social networks after his psychotic episode and was employed at the time of the initial interview. In addition, he had returned to university and was very involved in extra-curricular activities at stage 2.

Can FEP be considered a traumatic experience and if so, what are the traumatic aspects of this event?

A review of Tom’s interview data suggested that the experience of being psychotic was very distressing for him.

“The illness for me felt like a near death experience…I felt like I’d died.”

“It’s been one of the most traumatic experiences in my life and like I’ve lost my father before you know so I’ve had traumatic experiences but this was the worst. It puts you in a place you really don’t want to be.”

In relation to his treatment when unwell, Tom identified being “locked up,” the general conditions of the hospital, the hospitals rules and guidelines, staffs’ response to him, and being surrounded by other people who were unwell as difficult. Additionally, he identified his experiences with the legal system as distressing due to feelings of powerlessness, treatment by staff, and an incident of alleged physical assault.

“Yeah very distressing…I’d realised that there was still quite a lot of time that I had to spend in hospital there and…, it’s not fun spending time in a mental institution surrounded by people.
who had broken the law so…yeah it was pretty tough.”

“I was stuck in the hospital until a set date and I couldn’t do anything…I was the definition of powerless and to be in that situation was terrible and even worse when they took me to court they’d stick me in a room just a cell and not give me anything to eat or tell me the time or anything or wouldn’t even let me go to the toilet on one occasion and…that was hell being in there that was the worst place I’ve ever been in my life…..and I got bashed up in the cells there like obviously I had my illness and was blabbing and blabbing and the guys said well we’ll fix this guy up and bang bashed me up and that was a pretty low time in my life”

Tom discussed loss of control, powerlessness, and the awareness of being unwell and the disruptive nature of these issues as the main distressing features of his experiences.

“When the realisation kicked in that I was unwell that’s when things came crashing down to earth”

“…that’s obviously something I wouldn’t normally do…I’m shocked at how much my mind snapped”

Tom expressed ongoing apprehension and concern that he would become unwell again. He also appeared to demonstrate some avoidance of his experiences. Tom appeared acutely aware of his vulnerability.

“I’m a bit more wary of what could happen to me again it’s always in the back of my mind, I’m scared of having another breakdown again.”

“I just don’t want to go back to being out of control like not having control of my mind…it’s bloody scary.”

“I didn’t realise my mind was capable of the things that it was and…I’m scared that’ll happen again”

“I had a bit of a fright the other night I slept during the day and then I woke up at 12 and I couldn’t get back to sleep and I’m just thinking and buzzing and I thought the symptoms were coming back for a while there but it was just because I hadn’t had any sleep and like it was one night thing so and that was a week or so after they reduced my medication as well so I was worried. I just kept over thinking things and couldn’t get to sleep like I remember before the breakdown that’s what I was doing before the breakdown, just waking up really early and thinking too much so that was a bit of a fright but it was just a one night thing.”

“I don’t want to dwell on it I just want to live life now…I’d like to focus on more material things.”

Being unwell appeared to disrupt Tom’s sense of self. In particular, he tended to focus on the losses associated with his ‘external’ self. Tom described himself as outgoing and intelligent and indicated that these aspects of himself were directly affected by the experience of his psychotic episode.

“I’m a very smart person normally…I was just starring at the text and I couldn’t read”

“I used to be an extrovert…for that to be gone, that’s a bit upsetting”

“I felt totally out of the conversation loop and I’d just be sitting there thinking what am I doing, I used to be this outgoing very confident person and now I can barely hold my own in a conversation.”

Do FEP clients experience posttraumatic growth? If so, how is growth experienced amongst this population and what is their understanding of this transformation?
Tom discussed elements of posttraumatic growth, and it was relatively stable overtime. Specifically, he reported significant changes in the following areas: appreciation of life, relating to others, new possibilities, and personal strength. Tom did not identify growth in the fifth domain, spirituality.

“I don’t take life for granted…I feel like I’ve been given a second chance and I want to make the most of it.”

“Blessing in disguise…it gave me an opportunity to reassess what’s important in life”

“I didn’t know I was going to have this breakdown if I had of seen it coming may be I would have done things a bit differently like try to live life a bit more fully…now that I’ve gotten over the worst living life to the fullest is something I definitely intend to do…it doesn’t mean bouncing off the ceilings which is I probably what I used to think it meant it just means appreciating it more…making the most of you’re time…a different perspective that is impossible to have if you haven’t been where I’ve been…you appreciate life a hell of a lot more and I don’t think it is something you can have unless you’ve been through what I’ve been through…it’s something I passionately believe in”

“Before I took the express route…I’ve taken into consideration my illness and it’s a different path…to what it normally would’ve been”

“I’m closer to them than I ever was before” (family)

“They’ve stuck by me when I was at the very lowest…it teaches you a bit of loyalty to your friends…so now I’ve got more time for them”

“I’ve had my downs, I’ve been personally strong enough to overcome them and here I am…if before you told me what I was in for I would have may be caved in”

A difficulty with growth is determining whether it is illusory or actual change (Maercker & Zoellner, 2004). In an attempt to confirm the changes and growth Tom talked about in his interview, his mother was also interviewed. Her interview also provided a richer understanding of Tom’s experiences. Tom’s mother identified that he had changed his perception of his friends and family and said he had become closer to his sister. His mother also reported that Tom was more flexible of the fact that things don’t always go to plan in life.

“He’s more seeing them as people not the nerds he used to hang out with. Just as who they are, the way he used to see them” (friends)

“He thought of her whereas he never would of before…I think since this has happened they’ve been quite closer” (sister)

“I think he’s more tolerant. You know like things don’t always go according to plan”

What is the recovery pattern of FEP overtime in relation to the recovery styles sealing-over and integration? Can their patterns of recovery be conceptualised within the trauma and posttraumatic growth framework?

Tom presented with an integration recovery style at 5 months. Tom was aware of the continuity of himself throughout this experience as well as allowing new representations of the self to emerge (e.g., “Yep my sense of self identity is still the same. I still know who I am just may be externally I’m lesser of a person than I was”). He also tried to place his experience into some coherent perspective. For example:

“I just look at this illness as something like asthma…”

“I’ve always had set-backs in my life and I’ve just taken them on the bounce and managed to come back, bounce back so um like this illness I’ve just taken in its stride and dealt with it…”

Understanding Adaptation to First-Episode Psychosis
"…with hindsight like I can see it was good to slow down like I graduated then I worked like crazy to save up for (interstate) then I got to (interstate) and I was starting a new degree straight away, there was no gap between my last degree and going straight into the other one and so it looks a little crazy to me now that I’d do that, I should’ve taken the time off instead of working myself to the bone and then having this illness and so its also been helpful in that way, given me time to slow down”

However, Tom only tended towards integration at 8 months. At the second interview, there was a sense from Tom that he wished to return to his previous state rather than embrace the changes he had experienced. Even though Tom stated that his recovery was “gradual,” he also appeared to be urgently attempting to regain the things he had lost due to his psychotic episode.

“I’ve taken a detour.”

“I’ve got to get my personality back.”

“I want to get my life back on track and getting a law degree…will be proof”

Case Study 2. Sarah

Sarah, aged 25, was diagnosed with Bipolar Disorder I, with psychotic features. She experienced a two-week deterioration in the context of increased substance use. Sarah presented with religious, persecutory, grandiose, and paranoid delusions, and ideas of reference. She was thought to experience fleeting perceptual disturbances but she did not describe clear hallucinations. Police and the Crisis Assessment and Treatment Team were involved in her admission. When hospitalised she experienced seclusion, sedation, and admission to the high dependency unit. According to Leucht et al. (2005), Sarah could be considered mildly ill at both stages 1 and 2 (overall PANSS scores = 64 & 69 respectively) and a negative syndrome predominated at both stages but to a slightly lesser extent at stage 2 (stage 1 = 21 & stage = 18). At the time of data collection Sarah was quite isolated, had withdrawn from her friends, was unemployed, was not completing any study, and was sleeping a lot.

Can FEP be considered a traumatic experience and if so, what are the traumatic aspects of this event?

Sarah did not present with any symptoms consistent with a trauma reaction. However, she identified a number of distressing aspects of having been unwell. While Sarah acknowledged that her symptoms were difficult to experience, she tended to focus on her treatment experiences. She identified being isolated from her family, being surrounded by others who were unwell, being “locked-up” in hospital, police-assisted admission, being unable to make choices, not understanding why she had been admitted, and sedation and seclusion as difficult.

“Initially I found distressing the taking of medication especially when I was put in seclusion and all there was, was a mattress and I was already drugged out so I didn’t really know what was going on and all they’d do, like there was no contact with people so the only time I’d not really see anyone but see a hand would be when they were giving me my medication. They’d open the door slightly and give my medication I’d take it and then I’d be knocked out again. I didn’t understand why I was there in the first place”

“Being taken in by the police was a bit scary…I felt like a prisoner I guess being locked up…cause I’d prefer to be at home cause I didn’t think there was anything wrong at all so to be sent there was a shock to me”

“There were visions of a man and he was like scratching his head and that sort of scared me”

“I felt reluctant but I knew if I tried to, if I tried to stop them (Crisis Assessment and Treatment Team) from taking me it’d just get worse so I followed what they asked me to do
and I found that to be scary cause usually you have a choice…”

“One of the guys would like, he’d ask you to do something and then he’d push you afterwards onto the ground, that happened once… he didn’t physically hurt me it just sort of, mean, it sort of just hurt me, especially when he told me to tap him on the shoulder and I just thought that was weird so I did it and then he pushed me and I was like what was that for”

Like Tom, Sarah experienced ongoing hypervigilance about becoming unwell again which led her to be overly cautious and perhaps hindered her recovery.

“I’m going step-by-step at the moment instead of just jumping into the deep end cause that might trigger it off. I’m being cautious.”

“Yeah it’s just having to change what I do in knowing what might set me off I have to be cautious otherwise I may be sent back to the hospital and it’s not something that I want, I will allow to happen so I have to change what I do in order for that to occur”

Also, similar to Tom, Sarah discussed the theme of loss during her interviews. In particular, her sense of self and relationships also appeared to be significantly disrupted. Sarah appeared unsure of who her true self was as she seemed to question whether aspects of her personality prior to becoming unwell were indications of her illness. However, by the second interview Sarah was beginning to establish new representations of the self.

“It has…hindered our relationship or our friendship but my best friend… haven’t seen her as much… do miss her friendship”

“I used to be more bubbly in my personality…I sort of miss how I was before.”

“Sometimes I wonder if that side of my personality (bubbly) was due my condition…and that this is how I really am without that”

“I still think that in some ways that the bubbliness was my illness cause I’m still not that way but I am. In some ways I am still, it’s still a part of me it’s just not so pronounced as it was before because I think it heightens all the parts of your personality traits so I’m still that person but not to the same degree.”

Do FEP clients experience posttraumatic growth? If so, how is growth experienced amongst this population and what is their understanding of this transformation?

Sarah presented elements of growth and reported that her experience had caused her to “grow.” However, growth was less salient in her interview compared with Tom. Overall she presented more elements of growth at 5 months compared to 8. Like Tom, she reported changes in three of the five posttraumatic growth domains: appreciation of life, relating to others, and personal strength.

“I think it gives me a greater understanding of who I am…”

“Just going out and partying I enjoyed that…but in not doing that I realised that there’s more to life.”

“It enables me to have a higher regard for my family and friends. In some ways I tended to take them for granted whereas these days I try a bit harder in some ways”

“My relationship with my mother has improved…She (mother) helps me when I doubt myself…I wouldn’t have known that before or thought that before but I realise now….After and during this experience it has brought us closer together where I can rely on her (mother) both physically and emotionally to be there for me”

“I think I understand people with mental illness a bit more….the way they feel about things….I’d like to think that I’m more understanding now caused I’ve experienced something else which has caused me to grow”

“More self-reliant cause I used to…sort of depend on my friends but now I’ve realised that you’ve got to look after yourself before you can look after other people”

Sarah’s mother was interviewed. She reported that they had a closer relationship since Sarah had experienced her psychotic episode. In addition, Sarah’s mother said she had begun to discover new interests and indicated that her demeanour had changed.

“She’s been talking about, she loves animals she wants to work (with them)…no never talk about this…”

“She listens to me and she helps as well if I say to her would you be able to bring the washing? She does things.”

“I know she loves me and now it’s been really, really good. I think she knows more now mum loves me.”

“She’s sort of calm and talks and you know a gentle way, quite different.”

What is the recovery pattern of FEP overtime in relation to the recovery styles sealing-over and integration? Can their patterns of recovery be conceptualised within the trauma and posttraumatic growth framework?

Unlike Tom, Sarah tended towards an integration recovery style at 5 months. However, Sarah developed a full integration style at 8 months. She was aware of the continuity of herself at the time of the second interview and she appeared to develop more acceptance of her experience overtime. She also recognised permanent change during the second interview and was aware that her recovery took time, which was dissimilar to Tom who was urgently trying to return to his previous state despite recognising that recovery was “gradual.”

“I still think that in some ways that the bubbliness was my illness cause I’m still not that way but I am. In some ways I am still, it’s still a part of me it’s just not so pronounced as it was before because I think it heightens all the parts of your personality traits so I’m still that person but not to the same degree…They’re still there it’s just in varying degrees”

“I’m changing, I’ve changed”

“It’s an ongoing process” (recovery)

Summary and General Discussion

These case studies show that the notion of trauma and growth responses is relevant to recovery from FEP. Both Sarah and Tom indicated that FEP was a distressing experience. Sarah tended to concentrate on the stressful nature of treatment experiences and to some extent her symptoms, which is more in line with the literature (e.g. McGorry et al., 1991; Shaw et al., 2002). Contrary to previous research (e.g., Priebe et al., 1998), Tom focused on loss of control, powerlessness, and the awareness of being unwell as stressful. Like the literature suggests (Riedesser, 2004), both Sarah and Tom experienced disruption to their sense of self and Sarah mentioned the impact on her relationships. Additionally, they were concerned about becoming unwell again, particularly Tom. This appeared to lead Sarah to be overly cautious, whereas Tom was trying to urgently regain what he had lost. Tom also appeared to show some level of avoidance through his desire to distance himself from the experience.
Elements of posttraumatic growth were evident in these case studies. Both Sarah and Tom reported increased appreciation of life, deeper relating to others, and enhanced perception of personal strength, and Tom’s account also appeared relevant to new possibilities. However, overall growth was less salient in Sarah’s interview. It is possible that this is because Sarah appeared less traumatised than Tom and tended to demonstrate more acceptance of what had occurred. The literature suggests growth may only occur when it is preceded by, or occurs together with significant subjective distress (Calhoun & Tedeschi, 1998).

Tom and Sarah’s recovery styles changed overtime. While Sarah only tended towards integration at 5 months, she developed a full-integration recovery style at 8 months. In contrast, Tom had a full integration style at 5 months but only tended towards integration at 8 months. Even though both Sarah and Tom appeared to experience trauma reactions, Tom seemed increasingly distressed by his experience and appeared to demonstrate avoidance as well as hypervigilance. By the second interview he seemed to be attempting to distance himself from the experience and urgently regain what he had lost. Unlike Tom, Sarah gave the impression that she had developed more acceptance of her condition and acknowledged permanent change. Interestingly, Sarah’s integration style at 8 months corresponded with a decrease in growth and Tom’s level of growth remained fairly consistent across the two interviews despite a change in recovery style. While it seems that Tom and Sarah’s recovery patterns can be conceptualised within the trauma framework, these findings show that the relationship of growth to sealing-over and integration is complex.

From these case studies assumptions can be made about Sarah and Tom’s prognosis. One may suspect Sarah’s psychotic episode has impacted on her to a greater degree compared to Tom, given her isolation, lack of social support, unemployment, and poor sleep hygiene. In addition, it could be hypothesised that Sarah’s cautiousness about becoming unwell again and fewer accounts of growth might be impeding her recovery. Also, she presented with more symptomatology compared to Tom. Yet despite this, Sarah developed an integration recovery style, acceptance of her condition, and acknowledgement of permanent change.

In contrast, Tom appeared more distressed by his experience and displayed an urgency to recover. Also, his recovery style at 8 months suggests that he had not integrated the experience to the extent that Sarah had. Yet unlike Sarah who had few accounts of growth, Tom’s reports of growth were just as pronounced at stage 1 compared to stage 2. Subsequently, these case studies demonstrate that the relationship between recovery style and growth is complex. What can be surmised is that growth can be present in people of varying illness presentations. In conclusion, drawing on growth as well as the distressing nature of psychosis may broaden our definition of recovery from FEP.

### Conclusion and Implications

A number of conclusions and implications can be drawn from these case studies.

Chiefly, Sarah and Tom’s accounts indicate that FEP be considered a traumatic experience and elements of growth are relevant after this event. While sealing-over and integration recovery styles can be conceptualised within a trauma framework, their relationship with growth is less defined. Nonetheless, recovery, trauma, and growth are not discrete concepts in understanding FEP but rather they are all relevant to people’s accounts of this experience. However, how they pertain to people’s experiences FEP may vary. These case studies point to the importance of recognising individual disparity and appraisals when attempting understand the experiences of FEP, clients’ needs, and recovery pathways.

Tom and Sarah’s case studies show that people who develop a first occurrence of psychosis can have some self-awareness and a capacity to reflect on their experiences despite the very nature of their illness which cause them to be loose touch with reality. Therefore, it is important to begin having meaningful conversations with people about their experiences of FEP, which include discussions about the helpful and unhelpful impact of psychosis. While previous research focused the trauma associated with treatment and symptoms experiences (e.g., Shaw et al., 2002; McGorry et al., 1991), these case studies indicate that it is
also important to consider broader notions such as threat to one’s identity. Subsequently, other factors such as impact on clients’ sense of self and relationships, perceived vulnerability, feelings of hopelessness, and the awareness of being unwell are likely to be important foci in treatment.

Acknowledging potential growth may encourage clients and clinicians to consider other aspects of FEP rather restricting focus to measurable outcomes such as symptom reduction and other destructive factors. Being aware of the possibility for growth could help clinicians support it in their patients. Therefore, early intervention could include an opportunity for clients to work through the disruptive nature of psychosis as well as draw on constructive aspects of the psychotic experience, providing a more rounded approach and understanding to recovery. Allowing clients to discuss potential positive outcomes could provide a sense of hope, de-stigmatise their illness, recognise their capacity for resilience and strength, and help disband the pessimistic view of psychosis.

In conclusion, trauma and growth framework appear relevant to people’s accounts of recovery from FEP and should be considered in the treatment of FEP. However, further studies are required to understand the broader complexities of growth and how it relates to the experience of FEP and recovery from this event.

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