

**THE EXPERIENCE OF CHANGE AND PSYCHOLOGICAL GROWTH
IN PEOPLE WITH PSYCHOTIC SYMPTOMS:
A PHENOMENOLOGICAL APPROACH**

CLARE MAPPLEBECK, DCLINPSY.

**Thesis submitted to the University of Nottingham
for the degree of Doctor of Clinical Psychology**

DECEMBER 2010

Abstract

Objective. The present study explored people's subjective experiences of positive change to understand if experiences of growth are evident in people who have experienced trauma and psychosis.

Design. Purposive sampling was used to recruit seven participants from local mental health support groups. All participants reported a diagnosis on the schizophrenia spectrum of disorders and were interviewed using a semi-structured interview schedule designed for the purpose of this study.

Methods. Interviews were transcribed and analysed using interpretative phenomenological analysis.

Results. Participants described the processes involved in moving towards positive change, with the overarching theme describing a journey towards recovery. Two superordinate themes were identified in the study and included: 1) participants described a number of '**barriers to change**', highlighting the role of: 1a) the mental health system, 1b) the impact of psychosis and 1c) the stigma/rejection from others, and 2) participants highlighted a number of processes and experiences which helped them to '**adapt their sense of self**' and move forward towards growth and recovery and included 2a) finding meaning and purpose, 2b) support and understanding from and to others, 2c) developing inner strength and determination, and 2d) self-acceptance and awareness.

Conclusion. Participants described key changes in facilitating psychological growth and recovery, including: self-acceptance, adapting to their experiences, empathy for others and self-integration and identity re-formation. Social support, finding meaning and purpose and regaining control over their lives were also integral processes in facilitating growth and recovery. The discussion focussed on comparing the findings of the present study to research conducted in

the areas of psychosis, trauma, posttraumatic growth and recovery. It also highlighted the conceptual overlap between growth and recovery.

The study identified a number of clinical implications, including the role of the mental health system in limiting positive change and the potential for re-traumatisation, and the implications regarding the delivery of psychological therapies for people experiencing psychosis and trauma. A number of methodological considerations of the research are discussed, such as retrospective data collection, difficulty in recruiting a homogenous sample and the reliance on self-reported accounts of psychological growth. Suggestions for future research focus on the need for more investigations of the potential for psychological growth and recovery in people with a number of mental health problems. The relevance of the study was discussed in terms of understanding and identifying potential barriers to change, the need for greater assessment of trauma histories or trauma resulting from people's psychotic symptoms and adapting psychological therapies to facilitate psychological growth.

Keywords: Psychosis, Growth, Positive Change, IPA, Recovery

Acknowledgements

I would like to thank several people for their help and support.

Firstly, I would like to extend a heartfelt thanks to all participants who took part in my research. Without them, this research would not have been possible. Their stories have helped and inspired me to be a better psychologist. I would also like to thank the support groups and the Hearing Voices Network who helped with my recruitment.

Thank you also to Professor Stephen Joseph and Dr Rachel Sabin-Farrell for their guidance and support through all stages of my research and thank you to Dr Anna Tickle for her constructive feedback and in helping to make this a better paper.

Thank you to my Mum and Dad, and my sisters, for always supporting, encouraging and believing in me. Finally, I would like to thank my husband, Kieran, for his endless support, love, guidance and patience (and many hours of proof-reading). Without him, I would not have made it this far.

Statement of Contribution

The main author was responsible for the design of the project, applying for ethical approval, literature searching and the writing up of the literature review, participant recruitment data collection, data transcription and data analysis and the write up of the study. Professor Stephen Joseph aided with the design and analysis of the study and aided on drafts of the write-up. Dr Rachel Sabin-Farrell provided comments on drafts of the write-up and gave advice regarding recruitment.

Clinical supervision was provided by Professor Stephen Joseph. Research supervision was provided by Dr Rachel Sabin-Farrell.

Thanks also to Dr Jennifer Clegg for her early support in qualitative design and to Dr Shirley Thomas for her early research supervision of the project.

Table of contents

	Page Number
Journal Paper.....	9
Abstract.....	9
Introduction.....	10
Method.....	12
Participants and Recruitment.....	12
Interviews.....	13
Analysis.....	13
Validation Methods.....	14
Reflexivity.....	14
Results.....	15
1. Barriers to Change.....	16
2. The Adapting Self.....	18
Discussion.....	23
Conclusion.....	26
References.....	28
Psychology and Psychotherapy: Theory Research and Practice -	
Notes for Authors.....	32
Extended Paper.....	34
Extended Background.....	34
Literature Search Strategy.....	34
Introduction.....	35
Link between PTSD & Psychosis.....	35
Traumatic life events cause psychosis.....	38
Psychosis & PTSD are on a spectrum.....	41
Psychosis is a traumatic life event.....	43
Treatment of PTSD in psychosis.....	48
Psychological growth.....	49
Recovery vs. growth.....	53
Aims.....	57

Method.....	57
Study Design.....	57
Participants & recruitment.....	59
Interviews.....	61
Analysis.....	63
Validation methods.....	64
Triangulation.....	66
Data comparison.....	67
Transparency.....	67
Audit trail.....	68
Ethical considerations.....	68
Extended Results.....	71
1. Barriers to change.....	71
1a. Mental health system.....	71
1b. Impact of psychosis.....	75
1c. Stigma/rejection.....	77
Summary.....	78
2. The adapting self.....	79
2a. Finding meaning and purpose.....	79
2b. Support and understanding.....	82
2c. Inner strength and determination.....	85
2d. Self-acceptance and awareness.....	87
Summary.....	90
Extended Discussion.....	91
The Adapting Self.....	92
Evidence for Growth & Recovery.....	96
Barriers to Change.....	99
Trauma & Psychosis.....	103
Methodological Considerations.....	104
Clinical Implications.....	107
Future Research.....	110
Clinical Relevance.....	111

Journal Paper

The Experience of Change and Psychological Growth in People with Psychotic Symptoms: A Phenomenological Approach

Abstract

Objective. The present study explored people's subjective experiences of positive change to understand if experiences of growth are evident in people who have experienced trauma and psychosis.

Design. Purposive sampling was used to recruit seven participants from local mental health support groups. All participants reported a diagnosis on the schizophrenia spectrum of disorders and were interviewed using a semi-structured interview schedule designed for the purpose of this study.

Methods. Interviews were transcribed and analysed using interpretative phenomenological analysis.

Results. Participants described the processes involved in moving towards positive change. Two superordinate themes were identified: 'barriers to change' and 'the adapting self'. A number of subordinate themes were discussed within these.

Conclusion. Participants described key changes in facilitating psychological growth and recovery, including: self-acceptance, adapting to their experiences and self-integration and identity re-formation. Social support, finding meaning and purpose and regaining control over their lives were also integral in facilitating the process towards psychological growth. The study discussed clinical implications in relation to the changes needed in the provision of psychological therapies to aid and promote psychological growth in this population. Methodological considerations of the research are discussed and future research ideas are suggested.

Introduction

Research has suggested that individuals experiencing psychosis are vulnerable to secondary psychological difficulties, including depression (Birchwood, Iqbal, Chadwick & Trower, 2000), obsessive-compulsive disorder (Berman, Kalinowski, Berman, Lengua & Green, 1995), social anxiety (Pallanti, Quercioli & Hollander, 2004), and posttraumatic stress disorder (PTSD) (McFarlane, Bookless & Air, 2001; Read, Van Os, Morrison & Ross, 2005).

Recent studies investigating the link between PTSD and psychosis have outlined a complex set of inter-relationships. Morrison, Frame and Larkin (2003) delineate three possible relationships between psychosis and trauma: 1) traumatic life events cause psychosis, 2) psychosis and PTSD could both be part of a spectrum of responses to a traumatic event and, 3) psychosis is a traumatic life event that causes PTSD (Morrison et al, 2003) (see the extended introduction section for a more comprehensive discussion of this area). However, most of the focus in the area of trauma and psychosis has been on negative experiences. As reported by Linley and Joseph (2004), by focusing primarily on the negative aspects of trauma and adversity a biased understanding of posttraumatic reactions has been developed. Research has subsequently suggested that trauma can be a trigger to posttraumatic growth (PTG) (Calhoun & Tedeschi, 1999; Tedeschi & Calhoun, 1996), and so this would also suggest the possibility that for some, psychosis may prove to be a growthful experience (see the extended background section for a further discussion on posttraumatic growth).

According to Zoellner and Maercker (2006), PTG describes the experience of individuals who not only recover from trauma (as defined by returning back to pre-trauma functioning), but also use it as an opportunity for further individual development. The concept of growth is

conceptualised as different from the concept of recovery in the area of trauma and PTG and includes “*a movement toward more optimal functioning than they enjoyed prior to the event, rather than simply the maintenance of a previous equilibrium*” (Linley & Joseph, 2005, p. 263). PTG is thought to consist of five main categories of growth, such as appreciation of life, relating to others, new possibilities, personal strength, and spiritual change (Tedeschi & Calhoun, 1996). So far, little research has considered whether the concept of PTG is possible in people with psychosis who have endured traumatic experiences. In a review of the literature into psychosis and growth, only one study was identified as assessing the potential for growth in people with psychosis (Dunkley, Bates, Foulds & Fitzgerald, 2007). The authors found that psychosis was a distressing experience for the two participants recruited to the study, but that both participants demonstrated elements of PTG, including increased appreciation of life and deeper understanding of others. However, the research questions used in the study likely influenced the outcome of the themes; therefore it is hard to determine if these results reflect an actual process of recovery and growth or whether they are a product of the theme directed interview questions. Nevertheless, the study highlighted the possibility for the potential of PTG in this client group. The authors argue that it remains important to explore the relationship between psychosis and PTG in order to inform future treatment in this area. Saakvitne, Tennen, and Affleck (1998) argue that there is a need for more descriptive, idiographic research into the process of growth and change. This is in order to better develop a complete understanding of how respondents make sense of their lives (Massey, Cameron, Ouellette, & Fine, 1998).

Thus, the aim of the present study was to explore people’s subjective experiences of positive change to understand if experiences of growth are evident in people who have experienced trauma and psychosis. As looking at the potential for trauma and PTG in people

with psychosis is a relatively understudied area, it was considered more appropriate to start understanding the meanings and experiences that people have in this area. (see extended background for future discussion on the aims of the study)

Method

Participants and recruitment

A purposive sample of seven participants (five males, two females) were recruited to the study. Participant ages ranged from 28 to 68-years-old (median=40-years-old). A set of criteria was developed to ensure that the participants who were recruited were suitable to participate, including: 1) must be English speaking to ensure participants' understanding of language and concepts are in line with those of the researcher, 2) have the ability to provide informed consent to the study, 3) be over the age of 16 years old to ensure participants are able to give fully informed consent and, 4) live within 70 miles of the lead researchers base. Six participants were interviewed individually; one participant was interviewed with his wife.

Ethical approval was obtained from the Institute of Work, Health and Organisations at the University of Nottingham in July 2008 (see Appendix seven). Participants were recruited from two main networks; a national charity running groups nationwide and a support group local to the main researcher's place of work. The networks were contacted via the email address listed on their website to seek their cooperation in contacting the support groups directly to recruit potential participants (see Appendix three for details of email sent). After receiving approval, the lead researcher attended group meetings at different localities with different groups to discuss the research in more depth. Participants were given information outlining the study (see Appendix four) and were

encouraged to contact the researcher if they wished to take part in the study. Those who expressed interest were subsequently contacted by the main researcher and were invited for interview (see extended background for more information on participants and recruitment).

Interviews

Semi-structured interviews were used to develop a more in-depth understanding of the subject area. A general, open-ended question was devised to prompt participants in discussing their own story (e.g. *“tell me what your experiences have been like so far”*). The semi-structured interviewing format allowed the researcher to follow-up on any information provided by the participants, with general open-ended prompts (e.g. *“what was that experience like for you?”* and *“what sense did you make of X”*). All interviews were audio-recorded and transcribed by the main researcher in order to provide an accurate account of participants’ stories (see Appendix two for the interview schedule used and extended background for more information on the interviews).

Analysis

The present study employed a qualitative methodology utilising Interpretative Phenomenological Analysis (IPA) (Smith, 1996). The analysis followed guidelines by Smith and Osborn (2003). Each transcript was considered in turn, noting observations, interpretations of the narrative and the key emerging themes. Commonality and difference were noted for the emerging themes, which were then clustered to produce a list of themes. Connections between themes produced larger, superordinate categories. These were then checked against the original transcript to ensure they represented the experiences of participants. Each transcript produced a number of superordinate themes, which were checked against previous transcripts to ensure these themes had not been missed. An overarching list of

themes was developed for all transcripts and was reviewed by the second author to ensure reliability. The resulting themes for all transcripts were collated and the two researchers decided on which themes were the most appropriate and dominant in participants' stories. Each theme was then supported by a narrative account taken from participants' stories (see extended background for more information on the use of IPA, see Appendices eight to eleven for example of analyses carried out).

Validation methods

This research focuses on the meanings and experiences of people in the area of psychosis, trauma and growth and participants were selected for this reason. However, standards on qualitative research advocate considerations of validation and high quality research (Yardley, 2000). As a result, a number of measures were employed to assess validity of the present research, including: 1) triangulation, such as utilising an independent researcher when devising the interview schedule, and comparing the analysis of the interviews and subsequent coding of themes with the second author, 2) data comparison of the emerging themes, 3) transparency, such as keeping a reflexive diary and using participant quotes to support the themes, and 4) maintaining an audit trail of the analysis process (see extended background for more information).

Reflexivity

Due to the interpretative nature of IPA, it is important that the researcher is transparent regarding their personal beliefs, culture and experiences to ensure they do not unduly influence the interviews and subsequent analysis of themes. With this in mind, it is important for the researcher to indicate their own reflections, experiences or preconceptions during the whole research process in order for 'bracketing' to take place (Smith, Flowers & Larkin, 2009, p. 35).

The lead researcher is a 29 year-old female trainee clinical psychologist. Her occupation could have influenced the type of information that participants were likely to divulge – being a mental health professional could have produced both positive and negative reactions from participants, dependent on their experiences of this profession. The lead researcher also had a particular interest in trauma and psychosis. Therefore the lead researcher had some knowledge in the area and by being explicit about this, could 'bracket' these preconceptions and focus on the experiences produced by participants (see reflection section in extended discussion for more information).

Results

Results from the demographic information collected from participants (see Appendix one) indicated that all participants reported having had a psychiatric diagnosis on the schizophrenia spectrum of disorders. Six participants self-reported that their experience of psychosis had been traumatic, with one reporting that they were uncertain. The age of onset for psychotic symptoms varied between 4 and 58-years-old (median=19-years-old). Five participants described having religious beliefs or their own faith system. Four participants described themselves as being in a relationship and four participants reported they were currently working, through voluntary or paid employment.

The analysis was interested in understanding the participants' processes towards change, with one main overarching theme reflecting a story of participants' individual '*journey towards personal change*'. Within their stories were two superordinate themes, which were apparent in the narratives of all participants': 1) barriers to change, and 2) the adapting self. Within each theme, a number of subordinate themes also emerged. The following outlines the key themes that

appeared to be significant in participants' stories (these themes will be expanded upon in the extended results section).

1) Barriers to change

All participants described a number of barriers and restrictions to moving forward. Many participants discussed how they had overcome these barriers, but for some participants these issues continued to be pertinent, having a negative influence on their lives. There were three main barriers identified as hindering progress: a) the mental health system, b) impact of psychosis and, c) stigma/rejection.

1a) Mental health system.

The majority of participants described how entering the mental health system had been a hindrance to their overall progress. This was reflected with the way participants used a number of terms to describe the negative impact this had on their lives, particularly around hospitalisation, including “*hindrance*”, “*form of abuse*”, “*frightening*”, “*trapped*” and “*they made it worse*”. The negative connotations denote the barriers to change. Some participants described how the hospital was a service-led rather than a needs-led approach, whilst the hospital system was seen as unsafe and unable to meet their emotional needs. For many participants, the loss of hope instilled by the system was evident:

“When I first went in (to the psychiatric system) I was told I’d got erm I was told I was a chronic schizophrenic I would never ever work again and to go away and enjoy my life”
(Eddie, 56)

The passage reflects the antithesis of trying to enjoy life when Eddie has been presented with the idea that life will never be the same as before, and there is nothing left to enjoy. As the diagnosis was communicated in a negative way, this left him to become a “*revolving*

door patient” (Eddie, 60), due to his belief that he had nothing to improve or get better for. It also highlights the way the mental health system did not instil hope for change in Eddie. Participants described how this made them feel worse; the opposite of what is intended by the mental health system. In fact, Cathy also commented how her experience of this was “*more abusive than being raped*” (178), conveying how strongly she feels about the negative and traumatic impact this had on her life. It seems to reflect the idea of control and coercion within the mental health system.

1b) Impact of psychosis.

In the context of barriers to change, ‘impact of psychosis’ describes participants’ reactions to their psychosis, the disruption of their inner world and the negative feelings they attributed to themselves. For many participants, there was a feeling of loss of self, resulting in descriptions indicative of grief. For some participants there was a feeling that life had stopped, leaving some participants feeling stuck or frustrated.

“I have lost a lot of time having psychosis, erm time that I can’t get back and erm that makes me disappointed and angry” (Adam, 78)

Adam conveys a sense of real anger regarding the symptoms he experiences. It depicts the idea of ‘lost time’, as though his psychosis has slowed him down or been a hindrance to life moving forward. This idea was reflected by other participants, as though the psychosis itself was purposeful in making things worse.

Participants also described a number of comorbid psychological difficulties which produced a ‘vicious cycle’ through maintaining their negative self-perception and increasing their psychotic symptoms. For other participants, there was also the distress of re-experiencing past

abuse and traumas by way of flashbacks or due to their psychotic symptoms of paranoia and hallucinations:

“...my Granddad used to fiddle with me as his excuse to teach me to learn to swim...every time I go swimming I hear my Granddad’s voice...you don’t know where you are, you don’t know where you’re going all you know is that you can sense feel and hear all the issues to do with child abuse” (Beth, 111/129)

Beth conceptualises this well with the way these experiences continue to limit her life. She describes how she loses herself in her thoughts about her previous abuse and describes heightened senses as though she is acutely in tune with her experiences. Beth's whole being seems to be shrouded by the issues of abuse and this dominates her present self. It also demonstrates the difficulties participants have in moving forward from the psychosis and from their traumatic pasts.

1c) Stigma/rejection.

Some participants acknowledged how their diagnosis of psychosis resulted in negative appraisal by society, namely the stigma attached to their diagnosis and subsequent rejection by others. For many participants, this led to increased social difficulties, their feeling of being “different” (Adam, 182) and their mental distress.

2) The Adapting Self

Participants described a number of changes within themselves which helped facilitate personal growth and recovery. For the majority of participants, this followed internal processes, although a number of external mechanisms aided the changes. Subordinate themes included: a) finding meaning and purpose, b) support and understanding, c) inner strength and determination and d) self-acceptance and awareness.

2a) Finding Meaning and Purpose.

Most participants went through the process of trying to understand and make sense of their experiences, which for some participants proved to be important in moving towards positive change. For many, this involved trying to understand the meaning and purpose behind their psychosis and they used this to learn more about themselves and others.

“I was still searching for meaning and purpose and er again I tried to evaluate my own life and all this time I’m trying to work through it... If I’d just stopped and listened to the voices I’d have been there a lot quicker” (Eddie, 100/102)

There is the acknowledgement that making sense of their experiences is a difficult process. For Eddie, listening to his voices proved successful in helping him understand why he was experiencing them. This also proved helpful for other participants, along with trying to understand the origin of their psychotic symptoms.

The majority of participants described how as a result of their experiences with psychosis, their lives have changed for the better. For some participants, this is reflected in the way they describe their lives as more meaningful and purposeful now. This is demonstrated in a number of ways, from embracing life to contemplating their life in context. For example, due to their experiences of the negative aspects of life, they are more appreciative of the positives:

“...(life’s) a rollercoaster y’know with the thrills and spills ‘cos if you didn’t have the ups, the good times erm and if you didn’t have the bad times, you wouldn’t know what the ups were” (Cathy, 198)

Cathy uses the metaphor of a rollercoaster to understand her experiences. She describes how appreciating the positives in life came

from experiencing the negatives and implies that without one, you cannot experience the other. This way of viewing the world has helped her to adapt to her life and experiences. The use of a rollercoaster metaphor also conveys movement, possibly indicating the positive shifts in her life. This concept of movement was evident in many participants' stories through the use of metaphors. This portrayed an inherent sense of motivation to overcome obstacles and achieve positive outcomes.

2b) Support and Understanding.

Whilst most positive change was derived from intrapsychic processes, the role played by others was also important for all participants. Relationships also played a key role in encouraging and supporting participants. The importance of family and loved ones played a large part in helping people to move forward in their lives. For most, this reflected back to feeling understood, a sense of belonging and having someone to talk to. Relationships also moved beyond a purely supportive nature for some participants towards becoming role models to inspire positive change and a more positive outlook on their own lives:

“so my dad he became a positive person...so I look back and think yeah me Dad's done that and you know it's the way to go whereas some people that I've met through the outreach haven't really got a clue what to do, erm maybe because their Dads haven't been there...” (Frank, 102)

Frank's quote explicates the idea that people are influenced from an early age and he acknowledges the role his father played in shaping his own beliefs and outlook on life. He also contemplates the difficulties faced by those who did not have the opportunities that he has had and this seems to put his life in perspective.

Participants further reflected on how they had subsequently developed a greater understanding and empathy for others. This led some participants to recount stories of how they have supported and inspired others towards recovery.

2c) Inner Strength and Determination.

For most participants, overcoming many of the barriers to recovery was significant in promoting positive changes. For example, for some participants, there was an emerging story of how regaining control and power over their own lives was a catalyst for moving forward. One participant described how *“I’ve taken control back over my life and that is the main thing that’s helped me”* (Cathy, 174). This sense of empowerment was crucial for many participants to move forward.

“I can’t believe it’s happening really but it’s been a long climb you know I’ve had to believe deep down that something good will happen” (Frank, 80)

For Frank, determination and self-belief have been pivotal in helping him move forward in his life. The use of the word ‘climb’ portrays the difficulties he has encountered, but may also represent him moving upwards and onwards. It gives the impression of an inner drive to achieve positive change, which is also reflected by others:

“I’ve learnt from all that you have such strength inside and also you can adapt the way that you live and still live a full and meaningful life” (Cathy, 246)

For Cathy, inner strength was an important theme in her story, helping her to cope with and adapt to her experiences. This propelled her towards living her life in a *‘full and meaningful’* way and signifies a shift in her perspective, from viewing life as meaningless and hopeless

to embracing the whole of life. Adapting to life's challenges was also important in many participants' stories.

2d) Self-Acceptance and Awareness

For the majority of participants, the positive changes they made helped create a sense of psychological growth and development in their journey towards recovery. One of the most important facilitators of positive change involved acceptance and self-integration. This played a pivotal role in change for all participants who described it and refers to the way participants embraced their psychosis as a part of themselves, with their symptoms integral to this. This is reflected by Eddie, who describes how *"voices are a part of the self"* (180). For those who described an integrative self, there was a greater understanding of their symptoms and their identity:

"my recovery was quite rapid but my relationship with the voices changes because I was prepared to have a relationship with them...the voices that do speak and have some content they're parts of you, parts of yourself" (Eddie, 162/216)

Eddie describes the way he welcomes the voices he hears into his life. This represents a shift in perspective, from considering the voices he hears as a symptom of psychosis to perceiving them as a part of the inner self. This sentiment is reflected by Cathy, who also reports that having psychosis has *"made me accept me, I am who I am"* (174). This idea of acceptance appeared crucial for those participants who moved towards psychological growth and recovery.

Many participants described how through their experience of psychosis, they have developed a greater awareness of themselves. Furthermore, by embracing their experiences, some participants were able to move towards recovery as they fully accepted their symptoms

and experiences as changing them into the people they are now. They subsequently described learning from their life and their journey:

“I wouldn’t want anybody to go through it, but you realise how much you can achieve and how much you come through, come through the other end and actually it be positive and how much more there is to do, how much more there is in the future... but I’ve learnt so much and I’ve come a long way”
(Cathy, 256)

Cathy discusses how she has learnt about herself from her psychotic symptoms and how they have somehow changed aspects of her because of this. Cathy presents a greater feeling of hope for the future and acknowledges how far she has come in life. The idea of movement is evident in her story; the way she describes ‘*coming through the other end*’ gives a great sense of achievement.

Discussion

The purpose of the present study was to establish whether the potential for psychological growth was possible for people presenting with trauma and psychosis. Participants described their journey towards change and the subsequent positives that these changes fostered. For the participants who achieved psychological growth, there was a greater feeling of appreciation of life, finding meaning and purpose, inner strength and determination, understanding and self-awareness.

There were a number of clear similarities of growth demonstrated in this group of participants when compared with other research into trauma and growth. For example, the majority of participants portrayed a new sense of self, by viewing their psychotic symptoms as a part of the self. There was also a feeling that participants had fully accepted

this new sense of self. This concept of re-defining and reconstructing a sense of self and accepting their psychotic symptoms has been found in a recent review study (Bonney & Stickley, 2008). For most participants, life was described as being purposeful and they reported living a full and meaningful life alongside their symptoms. These findings support those presented by Dunkley et al (2007). In their investigation on growth following a first episode of psychosis, the authors reported evidence of an increased appreciation of life, relating to others and enhanced perception of personal strength. This also supports the finding that relating to others and personal strength leads to growth (Tedeschi & Calhoun, 1996).

Additionally, the above findings reflect similar conclusions found within the psychosis and recovery literature. Specifically, Andresen, Oades and Caputi (2003) reported a five stage model of recovery, with growth considered the final stage of this recovery model. This included having a positive outlook on life, living a full and meaningful life and having a positive sense of self. Other aspects of their recovery model included re-establishment of identity and finding meaning in life, both of which are reflected in the findings of the present study. It is, therefore, questionable whether psychological growth (or PTG) in people with psychotic symptoms is indeed a distinct construct from recovery (as it is considered within the trauma and growth literature), or whether growth is one final aspect of the recovery journey for people experiencing trauma and psychosis. These findings would point to the latter, and would acknowledge a conceptual overlap between the two constructs of growth and recovery.

Many of the barriers to change described by the participants in the present study were also reflected in other research. In the trauma and psychosis literature, research has identified how hospitalisation can be a traumatic experience (Calhoun et al, 2007), due to its stressful nature (Morrison, Bowe, Larkin & Nothard, 1999). Furthermore, the

negative and re-traumatising effect of psychotic symptoms is well established within the literature (Cusack, Frueh, Hiers, Suffoletta-Maierle & Bennett, 2003; Shaw, McFarlane & Bookless, 1997) (see extended discussion section for a greater discussion on the comparisons of the results of the present study with previous research.)

As acknowledged by Linley and Joseph (2003), the facilitation of PTG is not easily amenable to a manualised approach to treatment, such as cognitive behaviour therapy (CBT). The authors reported that a more client-centred, experiential approach may be more appropriate in the facilitation PTG. This view would fit with the findings of the present study, particularly as most manualised therapies target symptom eradication. This may not be helpful, as the participants who demonstrated recovery and growth in the present study described integrating their symptoms as a part of their self. However, the value of CBT has been demonstrated within this population, particularly in relation to reducing comorbid PTSD in people with psychosis, albeit with small sample sizes (Frueh et al, 2009, Jackson et al, 2009). Therefore, whilst CBT may not be the most appropriate treatment for facilitating growth, it may prove beneficial in reducing PTSD symptoms in people with psychosis. This is important as according to Schenkel, Spaulding, DeLillo, and Silverstein (2005), a history of trauma is associated with more severe psychiatric symptoms and poorer social functioning. Furthermore, therapies would also need to target a move towards self-acceptance and integrating service users' experiences of psychosis into their sense of self, where a more client-centred approach would be appropriate to facilitate growth (see extended discussion for more consideration of the clinical implications of the present study).

The study acknowledges its reliance on retrospective accounts of traumatic experiences of psychosis. Participants were also interviewed at different time periods following trauma and their diagnosis on the schizophrenia spectrum. These time differences may reflect the various

stages of change and recovery that participants discussed and the generational difference also needs to be acknowledged, with younger participants possibly being influenced by the recovery movement.

One of the limitations of recruiting from support groups is the likely influence of the group on people's interpretations of their experiences. Therefore, it is difficult to separate out whether the accounts provided by participants represent their own interpretations of their experiences or whether they represent the views of the organisation and support group they attended. However, the interpretations and beliefs of participants interviewed in this study varied within the groups they attended. Furthermore, if support groups are promoting a greater sense of growth and recovery in their members, then these groups are valuable in supporting others with mental health problems and in educating mental health services in fostering recovery (see extended discussion section for more information on methodological considerations).

Future research may benefit from the findings of this study, and those within the field of psychosis and recovery, to understand more fully the extent to which the positive concepts of inner strength and determination, finding meaning and purpose, the supportive role of self/others and developing self-acceptance has on facilitating the recovery process. By tangibly measuring these concepts, this could aid therapeutic attempts to facilitate such concepts in clients, to further support their recovery and psychological growth (see extended discussion for future research considerations).

Conclusion

Within this study there were a number of proponents which led participants towards recovery and psychological growth, including

adapting to the changes in their life and self-acceptance. Within the latter, the participants who spoke of accepting their psychotic symptoms as a part of themselves developed a more cohesive sense of identity and their story reflected this. This has implications for treatment and service delivery. The study also supports the idea that growth and recovery within the field of psychosis are indistinguishable concepts. As such, research within the post-traumatic growth field may be helpful in aiding positive change and recovery in those with psychosis.

Whilst it remains important that clinicians are aware of the potential for growth and recovery within people with psychosis, they are also encouraged to approach this carefully. As Calhoun and Tedeschi (2004) report, it should not be assumed that everyone could achieve psychological growth and recovery, thus promoting unrealistic expectations. Clinicians should instead aim to promote respect for the difficulty of trauma recovery whilst allowing for the exploration of possibilities for various kinds of growth, even in those who have suffered greatly.

References

- Andresen, R., Oades, L., & Caputi, P. (2003). The experience of recovery from schizophrenia: Towards an empirically validated stage model. *Australian and New Zealand Journal of Psychotherapy, 37*(5), 586–594.
- Berman, I., Kalinowski, A., Berman, S. M., Lengua, J., & Green, A. I. (1995). Obsessive and compulsive symptoms in chronic schizophrenia. *Comprehensive Psychiatry, 36*, 6-10.
- Birchwood, M., Iqbal, Z., Chadwick, P. & Trower, P. (2000). Cognitive approach to depression and suicidal thinking in psychosis. *British Journal of Psychiatry, 177*, 516-521.
- Birchwood, M., & Spencer, E. (2001). Early intervention in psychotic relapse. *Clinical Psychology Review, 21*(8), 1211–1226.
- Bonney, S., & Stickley, T (2008). Recovery and mental health: a review of the British Literature. *Journal of Psychiatric and Mental Health Nursing, 15*, 140–153.
- Calhoun, P. S., Stechuchak, K. M., Strauss, J., Bosworth, H. B., Marx, C. E., & Butterfield, M. I. (2007). Interpersonal trauma, war zone exposure, and posttraumatic stress disorder among veterans with schizophrenia. *Schizophrenia Research, 91*, 210–216.
- Calhoun, L. G. & Tedeschi, R. G. (1999). *Facilitating posttraumatic growth: A clinician's guide*. Mahwah, NJ: Lawrence Erlbaum.
- Calhoun, L. G., & Tedeschi, R. G. (2004). The foundations of posttraumatic growth: New considerations. *Psychological Inquiry, 15*(1), 93-102.
- Cusack, K. J., Frueh, B. C., Hiers, T., Suffoletta-Maierle, S., & Bennett, S. (2003). Trauma within the psychiatric setting: a preliminary

empirical report. *Administration and Policy in Mental Health*, 30(5), 453-460.

- Dunkley, J. E., Bates, G. W., Foulds, M., & Fitzgerald, P. (2007). Understanding Adaptation to First-Episode Psychosis: The Relevance of Trauma and Posttraumatic Growth. *The Australasian Journal of Disaster and Trauma Studies*, 1.
- Frueh, B. C., Knapp, R. G., Cusack, K. J., Grubaugh, A. L., Sauvageot, J. A., Cousins, V. C. et al. (2005). Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric Services*, 56(9), 1123-1133.
- Harrison, G., Hopper, K., Craig, T., Laska, E., Siegel, C., Wanderling, J. et al. (2001). Recovery from psychotic illness: a 15 and 25 year international follow up study. *British Journal of Psychiatry*, 178, 506–517.
- Jackson, C., Trower, P., Reid, I., Smith, J., Hall, M., Townend, M., Barton, K., et al (2009). Improving psychological adjustment following a first episode of psychosis: A randomised controlled trial of cognitive therapy to reduce post psychotic trauma symptoms. *Behaviour Research and Therapy*, 47, 454–462.
- Linley, P. A., & Joseph, S. (2003). Trauma and personal growth. *The Psychologist*, 16(3), 135.
- Linley, P. A., & Joseph, S. (2004). Positive change following trauma and adversity: a review. *Journal of Traumatic Stress*, 17(1), 11-21.
- Linley, P. A., & Joseph, S. (2005). The human capacity for growth through adversity. *American Psychologist*, 60(3), 262-264. DOI: 10.1037/0003-066X.60.3.262b

- McFarlane, A. C., Bookless, C., & Air, T. (2001). Posttraumatic stress disorder in a general psychiatric inpatient population. *Journal of Traumatic Stress, 14*(4), 633-645.
- Massey, S., Cameron, A., Ouellette, S., & Fine, M. (1998). Qualitative approaches to the study of thriving: What can be learned? *Journal of Social Issues, 54*, 337-355.
- Morrison, A., Bove, S., Larkin, W., & Nothard, S. (1999). The psychological impact of psychiatric admission: Some preliminary findings. *The Journal of Nervous and Mental Disease, 187*(4), 250-253.
- Morrison, A. P., Frame, L., & Larkin, W. (2003). Relationships between trauma and psychosis: A review and integration. *British Journal of Clinical Psychology, 42*, 331–353
- Pallanti, S., Quercioli, L., & Hollander, E. (2004). Social anxiety in outpatients with schizophrenia: a relevant cause of disability. *American Journal of Psychiatry, 161*, 53-58.
- Park, C. L., & Helgeson, V. S. (2006). Introduction to the Special Section: Growth Following Highly Stressful Life Events—Current Status and Future Directions. *Journal of Consulting and Clinical Psychology, 74*(5), 791–796.
- Read, J., Van Os, J., Morrison, A. P., & Ross, C. A. (2005). Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica, 112*, 330-350.
- Saakvitne, K. W., Tennen, H., & Affleck, G. (1998). Exploring thriving in the context of clinical trauma theory: Constructivist self-development theory. *Journal of Social Issues, 54*, 279-299.

- Schenkel, L. S., Spaulding, W. D., DiLillo, D., & Silverstein, S. M. (2005). Histories of childhood maltreatment in schizophrenia: Relationships with premorbid functioning, symptomatology, and cognitive deficits. *Schizophrenia Research, 76*, 273–286.
- Shaw, K., McFarlane, A., & Bookless, C. (1997). The phenomenology of traumatic reactions to psychotic illness. *The Journal of Nervous and Mental Disease, 185*(7), 434-441.
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health, 11*, 261–271.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage Publications Ltd.
- Smith, J. A., & Osborn, M. (2003). Interpretative Phenomenological Analysis. In J. A. Smith (Ed.) *Qualitative Psychology: A Practical Guide to Research Methods*. London: Sage Publications Ltd.
- Tedeschi, R. G., & Calhoun, L. G. (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9*, 455–471.
- Turpin, G., Barely, V., Beail, N., Scaife, J., Slade, P., & Smith, J. A. (1997). Standards for research projects and these involving qualitative methods: Suggested guidelines for trainees and courses. *Clinical Psychology Forum, 108*, 3–7.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health, 15*(2), 215-228. DOI: 10.1080/08870440008400302
- Zoellner, T., & Maercker, A. (2006). Posttraumatic growth in clinical psychology – A critical review and introduction of a two component model. *Clinical Psychology Review, 26*, 626–653.

Psychology and Psychotherapy (PAPTRAP)

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5000 words, although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Submission and reviewing

All manuscripts must be submitted via our [online peer review system](#). The Journal operates a policy of anonymous peer review.

4. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions

should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.

- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions. For further details please see the document below:  [Psychology and Psychotherapy: Theory, Research and Practice - Structured Abstract Information](#)
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

For guidelines on editorial style, please consult the [APA Publication Manual](#) published by the American Psychological Association.

5. Brief reports

These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

6. Publication ethics

All submissions should follow the ethical submission guidelines outlined the documents below:  [Ethical Publishing Principles – A Guideline for Authors](#)

 [Code of Ethics and Conduct \(2006\)](#)

7. Supplementary data

Supplementary data too extensive for publication may be deposited with the [British Library Document Supply Centre](#). Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

8. Copyright

On acceptance of a paper submitted to a journal, authors will be requested to sign an appropriate assignment of copyright form. To find out more, please see our [Copyright Information for Authors](#).

Extended Paper

The Experience of Change and Psychological Growth in People with Psychotic Symptoms: A Phenomenological Approach

Extended Background

Literature searching strategy

The literature included in the present study was subject to an extensive literature review carried out by the main researcher. Due to the large scope of the literature, a number of search terms were used, which are listed below. These were used in a variety of combinations using the Booleans and, or, not.

- Psychosis, schizophrenia, delusions, hallucinations, voices
- Posttraumatic stress disorder, PTSD, trauma
- Change, growth, posttraumatic growth, resilience, thriving, recovery
- IPA, interpretative phenomenological analysis, qualitative research

A number of electronic databases were used to search for relevant articles, including CINAHL, EMBASE, MEDLINE and PsycINFO, with dates ranging from 1990 to September 2009. Articles that were relevant to the research area were also read and any literature pertaining to the study within these was followed up. This way of finding relevant articles was used extensively throughout the literature review to find key texts outside of the strategy used.

Introduction

The term psychosis is used to describe the broad range of experiences which fall on the schizophrenia spectrum of disorders, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychiatric Association, 2000). The British Psychological Society (BPS) (2000) defines psychotic experiences as “...an umbrella term for unusual perceptions (e.g. hearing voices), or unusual beliefs. In both cases other people sometimes see the person as to some extent out of touch with reality” (BPS, 2000; p. 10).

The experience of psychosis can have a multifaceted impact, affecting many areas of an individual's life (TARRIER, 2005). Social and environmental pressures are considered to play a role in increasing symptomatology and psychological distress, including the impact of family and parental relationships (Schiffman et al, 2002), the public stigma of psychosis (Eisenberg, 2006), an increase in victimisation (TARRIER, KHAN, CATER & PICKEN, 2007) and limited peer relationships due to the onset of psychosis (Mackrell, & Lavender, 2004). In addition, a person's internal world can become disrupted resulting in a number of difficulties. This can include greater depersonalisation and derealisation resulting in a disruption to their sense of self (Lysaker & Lysaker, 2001; Sass, 2007), dissociation (Kilcommons, & Morrison, 2005), reduced self-worth and self-esteem (Wright, Gronfein & Owens, 2000) self-stigma (Vauth, Kleim, Wirtz & Corrigan, 2007) and cognitive difficulties (Kuipers et al, 2006) amongst others. There is also a higher prevalence of other mental health problems in people with psychosis, most noticeably with posttraumatic stress disorder (PTSD) (Chisholm, Freeman & Cooke, 2006).

Link between PTSD and psychosis.

Post-traumatic stress disorder (PTSD) is defined by the American Psychiatric Association (APA) (1994) as “a mental disorder

that arises from the experience of traumatic life events and includes symptoms of re-experiencing the traumatic event, hyperarousal, and avoidance of stimuli associated with the trauma” (p. 429). A person cannot be diagnosed with PTSD unless they have been exposed to an event considered traumatic. A variety of traumatic events have been implicated in the development of PTSD, including combat exposure (Iversen et al, 2008; Koren, Norman, Cohen, Berman & Klein, 2005) terrorist attacks (Shalev, 1992), criminal assault (Dancu, Riggs, Hearst-Ikeda, Shoyer & Foa, 1996) natural disasters (McFarlane & Papay, 1992; Neria, Nandi & Galea, 2008) childhood abuse (Cloitre, Koenen, Cohen & Han, 2002) and road traffic accidents (Holeva, Tarrier & Wells, 2001) to name a few. In a National Comorbidity Survey, 56% of respondents reported exposure to a traumatic event during the course of their lives (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995).

PTSD has also been identified as a comorbid condition in many psychiatric disorders. McFarlane, Bookless and Air (2001) found a prevalence rate of 33% in psychiatric inpatients that had experienced a previous traumatic event, with 28% meeting the formal criteria for a lifetime diagnosis of PTSD. This is compared to the lifetime prevalence rates of PTSD within the general population of between 5% and 11% and as high as 15% in combat veterans (Terhakopian, Sinaii, Engel, Schnurr & Hoge, 2008). The percentage of those identified with PTSD with an actual medical diagnosis range from 0% to fewer than 4% compared with reported prevalence rates of between 11% and 67% (Chisholm, Freeman & Cooke, 2006). If PTSD is being unrecognised by clinicians, then the PTSD will be left untreated and could result in both a complicated illness and poor treatment outcomes (Mueser et al., 1998).

According to Mueser, Rosenberg, Goodman and Trumbetta (2002), people with a ‘severe mental illness’ (such as schizophrenia) are more likely to be traumatised over the course of their lives than the

general population. Furthermore, 34% to 53% of people with a 'severe mental illness' report childhood sexual or physical abuse and between 43% to 81% report interpersonal violence. More specifically, research has indicated that there is a higher incidence of comorbid PTSD and psychosis compared with other disorders and the general population. Bogár and Perczel (2007) found that hospitalised patients with psychosis were significantly more likely to have comorbid PTSD when compared with controls. However, the authors' findings were only relevant to those with mainly positive psychotic symptoms. They concluded that psychotic patients with mainly negative symptoms were less likely to be traumatised. However, the results may not be generalised due to the small number of participants involved in this study. Calhoun et al (2007) have reported that PTSD regularly goes unrecognised in people with schizophrenia and other mental health problems, despite the high prevalence rates.

In a recent study, Lysaker & LaRocco (2008) studied trauma symptoms in 68 treatment seeking male combat veterans diagnosed with schizophrenia spectrum disorders, who had experienced at least one traumatic event. They found that two thirds of participants reported clinically significant trauma symptoms including intrusive experiences, defensive avoidance, or dissociation. The ability to generalise the results is questionable, as a different pattern may exist among younger persons with schizophrenia, non-veterans, or among persons who decline treatment. Furthermore, it has been reported that most studies that have cited high levels of comorbidity of PTSD and psychosis have been done with mainly treatment-seeking combat veterans with high symptomology (Deering, Glover, Ready, Eddleman & Alarcon, 1996). Therefore, it may be that psychosis has been over-diagnosed in combat veterans with PTSD and caution should be placed on studies using these particular samples in research studies.

Numerous studies have indicated a clear link between psychosis and PTSD, although the exact nature of this link is still unclear, with most discussions focussing on causality (Larkin & Morrison, 2006). Three main relationships between PTSD and psychosis have been reported: 1) traumatic life events cause psychosis, 2) psychosis and PTSD could both be part of a spectrum of responses to a traumatic event and, 3) psychosis is a traumatic life event that causes PTSD (Morrison, Frame & Larkin, 2003).

Traumatic life events cause psychosis.

A variety of early traumatic events have been implicated in the subsequent development of psychosis. These include: traumatic brain injuries (Achté, Jarho, Kyykkä & Vesterinen, 1991; Arciniegas, Harris & Brousseau, 2003; McAllister & Ferrell, 2002), vicarious traumatisation (Link, Victor & Binder, 1985), sexual assault (Kilcommons, Morrison, Knight & Lobban, 2008), bereavement/loss (Rheingold et al, 2004) and war trauma (Sautter et al, 1999). Most noticeable is the hypothesis that early childhood trauma can result in a susceptibility to psychosis. Of 144 psychiatric inpatients who reported childhood physical or sexual trauma, Ellason and Ross (1997) found that there was a significant association of reported childhood abuse in people with psychotic symptoms.

In a review of the literature, Read, Van Os, Morrison and Ross (2005) reported that child abuse is a causal factor for psychosis and schizophrenia and, more specifically, for voices and command hallucinations (see also Morgan & Fisher, 2007; Read, 1997, for further reviews in this area). These findings have also been replicated in numerous other studies in a variety of countries (e.g. Janssen et al, 2004; Morrison et al, 2002; Rosenberg, Lu, Mueser, Jankowski & Cournos, 2007; Shevlin, Houston, Dorahy & Adamson, 2008; Uçok & Bikmaz, 2007). However, as with many previous studies assessing

trauma and psychosis, the collection of data on traumas is generally retrospective, therefore it is unclear whether this is an accurate representation of participants' experiences. Previous studies have found that the accuracy of self reported trauma in people with psychosis may be inaccurate due to the confusion over their experience of intrusive delusions associated with their diagnosis (Tarrier, 2005). One such study has attempted to address these concerns by using a longitudinal method to collect the data. Bak et al (2005) conducted a three year follow up of 4045 non-psychotic individuals who were either exposed or not exposed to traumatic events prior to 16 years of age. They found that those who suffered increased emotional distress as a result of their traumatic experience were more likely to have had psychotic experiences compared with those without a trauma history. However, only a small number of the sample reported early trauma, therefore the differential effects of emotional, physical, sexual or psychological trauma could not be assessed.

Moreover, not all evidence in this area is conclusive. In a recent large National Comorbidity Survey investigating the aetiology of psychosis, Houston, Murphy, Adamson, Stringer & Shevlin (2008) did not find any significant effect of childhood sexual trauma or cannabis use. They did report a significant interaction between the two, however, only if cannabis was used prior to the age of 16. The authors did not provide evidence for why this might be, although it could be hypothesised that cannabis was used as a way to cope with their traumatic experiences. In fact, research has identified that dissociation after a traumatic event can increase a person's susceptibility to developing schizophrenia (Morrison et al, 2003); therefore this study may provide evidence of the effects of dissociation by using cannabis, rather than a causal relationship between the two.

In a personal account of her experiences of childhood abuse, Boevink (2006) reported that, "*I don't think that abuse itself is a strong*

cause for psychosis. It hurts, but it is rather simple. I think that the threat and the betrayal that come with it feed psychosis” (p. 18). This is only one person’s account of their experiences, which is likely to be different to other accounts of similar experiences. However, it helps to focus on other influences during childhood - such as core beliefs, social support and the reactions of others after traumatic experiences - as mechanisms for developing psychosis, rather than purely the result of a traumatic experience. Research to support this idea comes from a large-scale study (n=4045) by Janssen et al (2005) who found that levels of parental care were lower in those with psychotic symptoms, but they also found a strong main effect of trauma in this group. This could suggest that both the early trauma and subsequent reactions/care from caregivers was important in determining the development of psychotic symptoms. However, the authors concluded that although parental representations were on the pathway between early trauma and psychosis statistically, this is not enough to indicate that the experience of trauma was related to actual child–parent interactions and that further research in this area is required.

Overall, it would appear that there is evidence for a link between early trauma and psychosis. Shelvin et al, (2008) used data from two large samples; the National Comorbidity Study and the British Psychiatric Morbidity Study and found that experiencing two or more trauma types significantly predicted psychosis. The authors also reported the potential for a dose-response type relationship from the findings – indicating that increases in psychosis were likely to be associated with more trauma exposure. These findings echo those by Neria, Bromet, Sievers, Lavelle and Fochtmann (2002) who reported that cumulative trauma exposure may increase psychopathology in general and damage personality structures and basic capacities to feel, trust, and relate to others. Bogár and Perczel (2007) reported that a trauma history can often contribute to therapy-resistance, earlier

psychiatric treatment, more severe symptoms and the need to be hospitalised more often than those who have not experienced early traumatisation. It has been suggested that tailored interventions to address the adult consequences related to adverse childhood events may be necessary to improve outcomes for many clients with schizophrenia spectrum disorders (Rosenberg et al, 2007).

Psychosis and PTSD are on a spectrum of responses to traumatic events.

The least amount of research has been conducted in this area, although other studies have provided some evidence for a spectrum whilst investigating both previous traumas and trauma as a result of psychosis (Boevink, 2006; Jeffries, 1977). According to Deering et al (1996), prior to the classification of PTSD, many combat veterans were misdiagnosed as schizophrenic, demonstrating the similarity between the two conditions in relation to symptomatology and diagnostic features (Fleming & Richards, 2006). Furthermore, Bogár and Perczel (2007) reported intrusive flashback memories in patients suffering from PTSD, which appeared similar to the experience of hallucinations in patients with psychosis. Other similarities include isolating self from others, nightmares and oversensitivity. However, other studies have described such overlap in symptoms as 'pseudohallucinations'; that is, they are less serious than psychotic hallucinations (Heins, Gray & Tennant, 1990). Ivezic, Oruc, and Bell (1999) described two cases of PTSD accompanied by psychotic symptoms. They reported that the symptoms clearly differed from flashbacks but had a strong relationship to the trauma. The authors raised the question about whether there are two separate diagnoses or if psychotic symptoms are an integral part of PTSD. McGorry et al (1991) previously referred to this as 'postpsychotic syndrome' when there was evidence of PTSD with comorbid psychosis. It was concluded that the current classification systems may need to adapt to findings suggesting a link between PTSD

and psychosis, possibly to include a diagnosis of PTSD with psychotic features.

Further evidence for a spectrum of disorders comes from research into 20 war veterans with PTSD compared with 18 war veterans without PTSD (Butler, Mueser, Sprock & Braff, 1996). The results showed that there was a greater degree of depression, anxiety, agitation, anhedonia, and positive symptoms of psychosis in the PTSD group compared with the comparison group. The results also showed that the PTSD group had increased hallucinations and delusions and some of these were not related to re-experiencing previous traumas. This is obviously important, as there is potential for misdiagnosis in cases of PTSD with non-trauma related psychotic symptoms. However, the groups were not formally assessed to ensure there was no diagnosis of schizophrenia, nor were other confounding variables, such as drug or alcohol abuse (which have previously been linked to an increase in psychotic symptoms – Mueser et al, 2002), screened prior to commencing this study. Nevertheless, this study demonstrates that it is difficult to assess whether developing PTSD makes people vulnerable to psychosis, or whether people with psychosis are vulnerable to traumatic events and subsequently developing PTSD. However, it does provide evidence that the two disorders may co-exist as a response to a traumatic reaction and should, therefore, not be assessed in isolation.

Research investigating PTSD in severe mental illness (as defined by schizophrenia and major mood disorders) has also demonstrated similar findings. Mueser et al (2004) assessed 782 patients with severe mental illness in both inpatient and outpatient settings and found comorbid PTSD in 34.8% of patients. Furthermore, in patients with comorbid PTSD, there was a greater association between more severe symptoms, worse functioning and more frequent hospitalisations. It was reported that the findings demonstrate that

PTSD may interact with severe mental illness. There is a greater call for the diagnosis and subsequent treatment of PTSD in persons with mental illness (Mueser et al, 2004). The diagnosis of PTSD in this study was based on self-report questionnaires, making the accuracy of reporting questionable. However, Mueser et al (2001) have found that the questionnaires used in studies to measure PTSD are reliable and valid.

Psychosis is a traumatic life event that causes PTSD.

Due to the diagnostic criteria for PTSD excluding illness from the definition of a traumatic event (see DSM-IV-TR; APA, 2000), it was originally felt that psychosis could not be classed as a 'traumatic event'. However, Lundy (1992) studied a single case of a male adolescent with a diagnosis of schizophrenia that subsequently developed PTSD due to his experiences. Although the results of this study cannot be generalised, Lundy reported that a psychotic episode may meet the intent of the definition of a traumatic event in PTSD. More recent evidence is now confirming this belief. In one of the earliest studies to investigate PTSD following psychosis, McGorry et al (1991) assessed 36 in-patients with a 2-3 year history of psychosis and re-assessed them on two occasions during the year after discharge; once at four months and once at eleven months. The prevalence of PTSD was 46% at 4 months and 35% at 11 months. There was no relationship between first admission and symptoms of PTSD. Although the authors used self-report measures that were not validated, their findings (that PTSD was still present at 11 months when the psychotic symptoms had disappeared) suggested that PTSD followed psychosis in a sequential manner.

Shaw, McFarlane and Bookless (1997) report that psychosis has always been viewed as the most severe of the functional psychiatric disorders, as it involves disruption of reality testing, perception, and

thought processes. It is now being increasingly recognised that a psychotic episode can be perceived as a potentially traumatising event that can lead to symptoms of PTSD. The delusions and hallucinations experienced by someone with psychosis can include fears of being killed, being raped, killing others, bodily invasion and pregnancy as well as disturbing command hallucinations. Shaw et al (1997) report that there is no escape from this internal chaos and this creates a sense of extreme helplessness and threat. It is the stress of the symptoms of psychosis that can lead to a traumatic reaction and the person may subsequently develop PTSD symptomatology. In fact, studies with differing methodologies have found different rates of post-psychotic PTSD ranging from 11% to 67% (Chisholm et al, 2006).

There are two main outcomes in the investigation of psychosis as a pre-stressor to traumatic reactions: 1) that hospitalisation and the reactions of others may cause trauma and, 2) that the symptoms of psychosis, such as delusions and hallucinations, are traumatic enough to develop PTSD. There is considerable overlap between the two, with research giving evidence for the effects of both.

According to Morrison, Bowe, Larkin and Nothard (1999), admission to psychiatric hospital (particularly compulsory detention and involuntary treatment) is "*possibly one of the most stressful aspects of experiencing mental health problems*" (p. 250). They investigated this hypothesis by contacting 263 participants randomly sampled from admission records of local psychiatric hospitals over a six-year time frame. Of the 34 participants that responded, 44% of these patients exhibited levels of PTSD that met clinical caseness, with most patients exhibiting strong and varied emotional responses to such admissions, supporting the suggestion that psychiatric admission causes pervasive distress in both involuntary and voluntary patients. However, caution is needed when interpreting the results as with most studies in this area, the small sample size may bias the results. Furthermore, support for

this finding has been mixed. Priebe, Bröker and Gunkel (1998) failed to find a correlation between PTSD symptoms and previous involuntary hospital admission in people with schizophrenia. However, the study failed to measure other possible explanations for the high PTSD scores in this sample and acknowledged that they could not rule out the effect of the experience of acute or chronic psychotic symptoms in causing the traumatic symptoms. In fact, support has been found, most noticeably from the research carried out by Tarrier et al, (2007) where they found that as a result of the onset of psychosis, 77% of the 35 participants indicated they had suffered loss or disruption to their life, 60% had thwarted future aspirations, 38% had suffered violence or harassment, 53% had suffered stigma and 50% social exclusion. In total, 80% felt they had been traumatised by their treatment and 38% were cases for symptomatic-PTSD. However, as with most research in this area, the study is let down by modest numbers and a high refusal rate.

Research has also suggested that those with psychotic illnesses are at an elevated risk of being assaulted (Dean et al, 2007). Furthermore, lifetime rates of interpersonal violence in these individuals are also high, ranging from 51% to 97% (Goodman, Rosenberg, Mueser & Drake, 1997). This has been confirmed where studies assessing a variety of adult psychiatric patients found high rates of lifetime trauma that occurred in psychiatric settings (Frueh et al, 2005). This included physical assault (31%), sexual assault (8%) and witnessing a traumatic event (63%). Furthermore, rates of potentially harmful experiences were also high in other areas, such as being around frightening or violent patients (54%), seclusion (59%), restraint (34%), takedowns (29%) and handcuffed transportation (65%) (Frueh et al, 2005). These findings obviously have implications for the experiencing of a variety of traumas in people with mental health problems. It would appear that this group are more vulnerable to

traumatic experiences; therefore the comorbidity of PTSD is understandable in this population. The study assessed events occurring at any point in their lives; therefore the accuracy of self-reports is questionable. Furthermore, it is unclear whether the study also assessed exposure to traumas prior to developing psychiatric disorders, which may exacerbate their current symptoms and increased vulnerability to trauma. Nevertheless, the findings have been supported in previous studies where the impact of the psychiatric inpatient setting can be perceived as a frightening and dangerous environment and thus results in traumatic experiences for individuals (Calhoun et al, 2007).

In researching the latter, Chisholm et al (2006) investigated the presence of PTSD symptoms in 36 individuals with delusions and hallucinations in relation to their most recent psychotic episode. The results indicated that 61% of the individuals with remitted positive symptoms had a reaction to their psychotic episode that was potentially severe enough to receive a PTSD diagnosis. Furthermore, participants who reported being more helpless, being less in control during the episode and perceived their social support to be low, had higher traumatic stress responses. Moreover, previous experience of traumatic events was associated with PTSD symptoms. Chisholm et al (2006) identified that psychosis-related factors may make PTSD symptoms more likely. For example, an examination of the content of persecutory delusions indicated an increased perception of threat and higher trauma scores. The authors concluded that the belief that they will come to harm, being involuntarily admitted to hospital, the shattering of previously held assumptions about the self and threats to resources such as the ability to work, all contributed to a traumatic reaction. Chisholm et al recommended caution with the results, as PTSD symptoms may change with longer follow-up, although the results are promising in investigating the effects that psychosis can have in developing traumatic reactions. Furthermore, Mueser and Rosenberg

(2003) proposed that the experience of a first episode of psychosis and its treatment may be conceptualised as a traumatic event with the potential of leading to PTSD-like problems. However, whilst research has provided evidence for this link, Jackson, Knott, Skeate and Birchwood (2004) failed to find support for this in those experiencing a first episode of psychosis. They reported that psychotic symptoms were positively related to retrospective accounts of a stressful ward environment and the type of coping skills adopted. However, the findings consisted of only preliminary evidence due to the small sample size (n=35).

Shaw et al (1997) found support for both areas whilst investigating whether a psychotic illness was associated with PTSD symptomatology in 45 participants recovering from hospitalisation for a psychotic episode. The study found that a loss of control such as detention, and psychotic symptoms (particularly persecutory delusions, passivity phenomena, and visual hallucinations), were perceived as highly distressing by all participants and that 52% of the participants met the criteria for a postpsychotic PTSD. It was felt that hospitalisation was a predictor for the development of PTSD symptoms. The authors felt that postpsychotic PTSD was underestimated in this population as more disturbed patients were excluded from the study. These results were further supported in a follow up to this study, where the authors reported that all participants found psychosis and hospitalisation highly distressing and 52.3% of these participants met the criteria for postpsychotic posttraumatic stress disorder, even after controlling for the effects of previous traumas (Shaw, McFarlane, Bookless & Air, 2002). Overall however, the sample size in both studies was relatively small and the authors reported that it was difficult at times to distinguish between a delusion and intrusive memories of that experience. It is difficult to determine how this can be addressed due to the similarity of symptomatology in PTSD and psychosis. Furthermore, as with most

studies investigating the links between psychosis and trauma, most data is collected retrospectively after experiencing a traumatic event. This obviously has implications with the reliability of self-reports and other confounding variables, including the presence of psychosis/PTSD prior to the more recent trauma. However, research investigating the reactions of people with schizotypy disorder with no history of trauma have found an increase in trauma symptomatology compared with controls after watching a trauma video (Holmes & Steel, 2004). Taking all studies into account, it would appear then that people with a diagnosis of psychosis are more susceptible to developing intrusive trauma memories compared with non-clinical populations.

As indicated above, there appears to be evidence to support the three possible relationships between trauma and psychosis. There is also evidence that early traumas can lead to the development of psychosis, and that the subsequent psychotic symptoms can lead to re-traumatisation (Cusack, Frueh, Hiers, Suffoletta-Maierle & Bennett, 2003). As a result, Morrison et al (2003) have proposed that an integrative approach to this area is needed.

Treatment of PTSD in psychosis.

As previously described, the assessment of trauma reactions in people with psychosis has been neglected. One of the reasons for the neglect of assessing traumatic symptoms in psychosis may be due to the reluctance of clinicians to assess for a disorder where there are no guidelines for treatment (Resnick, Bond & Mueser, 2003). Furthermore, Read and Ross (2003) argue that as the focus on psychosis remains predominantly in the biological field, rather than resulting from psychosocial stressors and trauma, clinicians are less likely to ask about trauma histories and rarely offer subsequent psychological therapies. There is, however, emerging evidence that cognitive behavioural therapy (CBT) including aspects of psychoeducation,

relaxation training, and cognitive restructuring are feasible, safe, and effective in reducing PTSD symptoms in patients with schizophrenia spectrum disorders (Rosenberg, Mueser, Jankowski, Salyers & Acker, 2004). This has recently been supported in a randomised control trial, where 108 clients with mood disorders or schizophrenia were randomly assigned to either a CBT programme or a treatment as usual (TAU) group. Mueser et al (2008) found that clients in the CBT group improved significantly more than the TAU group on PTSD symptoms, negative trauma-related cognitions, improved working relations and in reducing other psychiatric symptoms (including anxiety and depression). However, there was no overall reduction in PTSD diagnosis in either sample and the number of participants with schizophrenia in the study were low (15%), therefore the results may not be generalised to this population and as the study focused primarily on PTSD; the effectiveness on psychiatric problems is unclear.

Psychological growth.

Psychological growth is described using a variety of terms within the literature, such as posttraumatic growth (PTG), stress-related growth, perceived benefits, flourishing, thriving and adversarial growth to name a few (Joseph, Linley, Shevlin, Goodfellow, & Butler, 2006). It was proposed by Smith and Cook (2004) that this psychological change does not negate the experience of psychological trauma but emphasises that in spite of adversity, many may find new meaning and purpose that inspires them to positive personal change. PTG in relation to PTSD is considered an independent, distinct construct (Zoellner & Maercker, 2006). That is, the two are not considered to be on the same continuum at either end, but rather growth is believed to be conceptually distinct from emotional adjustment.

It has been very difficult to determine the exact reasons and processes of positive psychological change and growth although

numerous studies have attempted this. For example, Tedeschi and Calhoun (2004) reported that the process of growth is complex and is based on a variety of factors including individual characteristics, ability to manage emotions, degree of self-disclosure of emotions and how others respond to this self-disclosure. Furthermore, they proposed that how the individual processes the traumatic events (demonstrated by ruminative thought) and the development of the individual's life narrative play a crucial role in PTG. Linley and Joseph (2004) conducted a review of the published empirical data on growth. They reported, "*problem-focused coping, as well as acceptance, positive reinterpretation, and positive religious coping were positively associated with growth*" (p. 16). The review concluded that cognitive appraisal variables (e.g. threat, harm, and controllability), problem-focused, acceptance and positive reinterpretation of the event, coping, optimism, religion, cognitive processing, and positive affect were consistently associated with growth. These variables are considered to be important in detecting and fostering the potential for growth in clients and clinical work. The evidence for growth and coping was further supported in a review by Zoellner and Maercker (2006) where they found that positive re-interpretation coping is positively correlated with reported personal growth. This has been demonstrated in a variety of clinical groups including people with breast cancer, spinal cord injuries and political prisoners (Zoellner & Maercker, 2006). However, the exact nature of the role of growth is questionable. The presentation of different concepts for the phenomenon of PTG has artificially opposed PTG as a coping strategy to PTG as an outcome of coping. However, many theorists acknowledge that PTG can be both coping style and coping outcome, and that these two modes can include differentially adaptive proportions (e.g. Affleck & Tennen, 1996; Calhoun & Tedeschi, 2004; Maercker & Zoellner, 2004).

Recent research considering growth following trauma include a qualitative study looking at positive change processes and PTG in people who have experienced childhood abuse (Woodward & Joseph, 2003). A thematic analysis was carried out on the narratives of 29 participants who reported experiencing childhood abuse. The analysis produced three main domains known as: inner drive, vehicles of change and psychological changes. According to the authors "*the domains represented a distinction between what seemed to us to reflect: first of all, factors internal to the person; second, psychological processes that were triggered by person-environment interactions; and third, descriptions of psychological changes*" (p. 273). Other areas which have received empirical findings include war trauma (Maguen, Vogt, King, King, & Litz, 2006), breast cancer (Mosher, Danoff-Burg & Brunner, 2006), disaster workers (Linley & Joseph, 2006), sexual abuse (Lev-Wiesel, Amir, & Besser, 2005), bereavement (Engelkemeyer & Marwit, 2008) and brain injury (Collicutt McGrath & Linley, 2006) to name a few. According to Joseph, Linley and Harris (2005), the breadth of studies suggest that a wide range of life events, from those considered stressful to those considered traumatic can all precipitate personal growth and positive change. Zoellner and Maercker (2006) reported that, "*If posttraumatic growth is a phenomenon worthy to be studied in clinical research, it is assumed to make a difference in people's lives by affecting levels of distress, well-being, or other areas of mental health*" (p. 631). Therefore, it is important to study the effects of growth in people with mental health problems due to the potential for positive change.

There is a growing body of evidence to suggest that a variety of traumatic stressors can result in growth. Generally, research studying PTG in people with mental health problems has been neglected, although the research so far has produced mixed findings (see Park & Helgeson, 2006 for a review). In a longitudinal study assessing sexual

assault survivors 2 weeks and 12 months after the assault, Frazier, Conlon and Glaser (2001) found that depression and PTG were significantly negatively correlated and that those individuals who gained positive changes from time 1 to time 2, or who always had experienced benefits, were significantly less depressed 12 months after the traumatic assault. However, there was no positive relationship between PTG and depression. The authors did acknowledge that the study was limited due to the small sample sizes; therefore the power of the study was relatively weak. Furthermore, they reported that the data did not address whether survivors' reports of positive change reflect actual life changes or positive illusions created to cope with the trauma. However, it may be difficult to separate the two out and it is unclear how this could be better managed. Therefore, the relationship between psychological distress and PTG remains unclear. One explanation is proposed by the two-component Janus-Face model of PTG. Maercker and Zoellner (2004) propose that PTG has a functional side and an illusory, dysfunctional side. The former is thought to be correlated with healthy adjustment whereas the latter perceives PTG as distorted illusions that counterbalance emotional distress (Zoellner & Maercker, 2006). Support has been found for the illusory component of PTG (McFarland & Alvaro, 2000; for a review, see Zoellner & Maercker, 2006). In order to distinguish between the two, the authors reported that growth should be positively correlated to psychological adjustment.

As previously discussed, there is a high comorbidity of previous traumas and PTSD in people with psychosis, more so than the general population and other mental health problems (Mueser et al, 2002). That is, the experience of psychosis can also result in traumatic reactions, similar to those experienced in PTSD. However, there has been limited focus within the literature on growth in people with psychosis, with only one study addressing the relationship directly (Dunkley, Bates, Foulds & Fitzgerald, 2007).

Recovery vs. growth in psychosis.

According to the trauma and PTG field, the connotation of the term 'recovery' denotes that the person has returned back to the way they used to be (pre-trauma functioning - Tedeschi & Calhoun, 2008). This is not always possible for someone who has experienced major changes and disruption to their lives due to their diagnosis of schizophrenia and the possible trauma resulting from this (Mueser & Rosenberg, 2003). However, the definition of recovery within the psychosis literature is moving more towards a personal consumer-led definition as highlighted by the definition of the National Institute for Mental Health in England (NIMHE):

“Recovery is not just about what services do to or for people. Rather, recovery is what people experience themselves as they become empowered to manage their lives in a manner that allows them to achieve a fulfilling, meaningful life and a contributing positive sense of belonging in their communities” (NIMHE, 2005).

Nevertheless, Silverstein and Bellack (2008) acknowledge the lack of consensual definition of recovery. They report that the different definitions can be organised into two types: 1) those that reflect recovery as an outcome based on whether operationally defined criteria in one or more domains are met, and 2) those that reflect recovery as an ongoing process of identity change including a broadening of self concept wherein the role of consumer of psychiatric services becomes less pronounced. More recently, Wunderink, Sytema, Nienhuis and Wiersma (2009) refer to the terms symptomatic remission, denoting the remission of clinical symptoms, and functional remission, implying a return to social functioning in the main domains of everyday life such as personal care, living, working and relating to others. This way of viewing recovery is based on Davidson, Schmutte, Dinzeo and Andres-

Hyman's (2008) view of "*in-recovery*" vs. "*recovery from*" schizophrenia. However, some studies still use symptomatic remission as a benchmark for recovery in schizophrenia, particularly in outcome-orientated research (e.g. Bobes et al, 2009). For example, Harrison et al (2001) carried out one of the largest studies to date. In the International Study of Schizophrenia, they studied 1633 participants diagnosed with psychosis (either schizophrenia or other psychosis) and then traced 1005 of these original participants for the 25 year follow-up. Harrison et al found that in 50% of the surviving cases, a significant proportion of treated incident cases of schizophrenia achieved favourable long-term outcome (50%). It was found that socio-cultural conditions modified the long-term course and that earlier intervention predicted better long-term outcome. However, the study did not assess relapse rates within this population, which have been shown to be moderate in other studies (Birchwood & Spencer, 2001). Furthermore, the study relied heavily on the exacerbation of symptoms, service utilisation and social disability to predict recovery, therefore it does not equate with the consumer-led view of recovery. However, the historic nature of the study suggests that recovery is possible in people with psychosis.

Many factors have been implicated in facilitating recovery, including supportive family/caregivers, absence of substance abuse, a shorter duration of untreated psychosis, good initial response to neuroleptics, adherence to treatment and supportive therapy with a collaborative therapeutic alliance to name a few (Lieberman, Kopelowicz, Ventura & Gutkind, 2002). In addition, Roe (2001) has identified a number of factors that help facilitate the recovery process, including the importance of work, expectations and attitudes towards treatment, building relationships, generating a functional sense of self, developing purpose and meaning in life, develop an understanding of symptoms and gaining control over symptoms. In addition, self-esteem (Kupper & Hoffman, 2000), self-efficacy (Silverstein et al. 2006), hope (Windell,

Norman & Malla, 2006) and coping styles (Vauth, Kleim, Wirtz & Corrigan, 2007) have been implicated in facilitating recovery from schizophrenia. However, many of these concepts are considered vague and it is not yet known to what extent these are necessary conditions for recovery (Bellack, 2006). Furthermore, it still remains unclear whether these factors are related to the recovery process, the extent to which people with these characteristics are more likely to experience themselves as engaging in a recovery process, and whether these factors are related to the degree of recovery-oriented personal transformation that can be achieved (Silverstein & Bellack, 2008).

Bonney and Stickley (2008) have subsequently attempted to determine commonality amongst the concept of recovery in mental health patients. They reviewed over 170 papers on recovery in mental health and by using thematic analysis, six dominant themes emerged: 1) identity (such as redefining identity, reconstructing a sense of self and accepting and understanding psychotic experience), 2) the service provision agenda, 3) the social domain (such as being integrated into society), 4) power and control (including given choice and facilitating empowerment), 5) hope and optimism, and 6) risk and responsibility. This method was also used by Andresen, Oades and Caputi (2003) in identifying a model of recovery, including: 1) moratorium (denial, confusion, hopelessness), 2) awareness (hope at a better life, recovery as possible), 3) preparation (starting to work on recovery), 4) rebuilding (working to forge a positive identity, taking responsibility for managing illness), and 5) growth (the person may not be free of symptoms but knows how to manage illness, is resilient after setbacks, and has a positive sense of self).

Whilst there appears to be some overlap in the conceptual definitions of growth and recovery, many within the PTG field still consider these concepts to be distinct. In the field of trauma and growth, a number of models have been proposed to conceptualise

growth following adversity and help to distinguish between recovery and growth (see Zoellner & Maercker, 2006, for an extended review). According to O'Leary and Ickovics's (1995) model of discontinuous change, there are three possible outcomes following trauma: 1) return to the old level of functioning (recovery), 2) return to a lower level of functioning (survival), and 3) return to a higher level of functioning (thriving). Therefore, in this definition, recovery is not considered growth or personal change; rather, the person is able to go back to their original level of functioning without the possibility of personal development, growth or positive psychological changes. This idea is further supported by the work of Joseph and Linley (2005) in their organismic valuing theory (OVP) of growth following adversity. This theory appears to build on the social-constructivist assumptive world's model (Janoff-Bulman, 1992) to describe how humans are believed to be inherently motivated to pursue well-being in life. When the social environment supports this drive, they will move towards fulfilling this inherent need. When a trauma is experienced, there is a breaking down of existing assumptions about the self and the world. The OVP therefore states that within this scenario, people are motivated to build their assumptive world whilst incorporating the new trauma-related information. However, according to Joseph and Linley (2005), trauma information is incompatible with existing models of the self and the world. Due to this incompatibility, people are motivated to either revise their pre-trauma assumptions to take into account the trauma-related information (they 'accommodate' to their experiences) or they view the trauma-related information as being consistent with their previous assumptions (they 'assimilate' to their experiences). Joseph and Linley report that assimilation involves restoring their previous assumptions of the self and the world, whereas accommodation incorporates new information to re-develop their assumptions. Within accommodation however, this information can be either positive or negative, therefore resulting in three potential psychological outcomes: 1) assimilation

(resulting in a return to pre-trauma baseline functioning), 2) negative accommodation (such as PTSD), and 3) positive accommodation (such as PTG). It is, then, the process of facilitating positive accommodation of experiences that might promote growth in people who have experienced traumas.

Aims.

As previously discussed, it has been difficult to determine the exact reasons and processes of positive psychological change and growth. According to Linley and Joseph (2003), early indications are that people who report more growth in the aftermath of trauma go on to show better long-term adjustment. In exploring the field of trauma and PTG, the present study aims to understand whether PTG is possible in those people who have experienced a traumatic episode of psychosis. In relation to the field of clinical psychology, it is hoped that if the study demonstrates the potential for growth in people with psychosis, the findings may influence future interventions and models of change and growth, along with helping psychologists inspire and foster change and growth in their own clients.

Method

Study Design

In order to investigate the area of psychosis and growth, it is important to conduct research which takes an individual perspective on participants' experiences. One such area that has attempted to understand a wide variety of perceptions and experiences from the perspective of the individual is Interpretative Phenomenological Analysis (IPA) (Smith, 1996). The main aim of IPA is to, "*explore in detail the processes through which participants make sense of their own experiences, by looking at the respondent's account of the*

processes they have been through and seeking to utilise an assumed existing universal inclination towards self-reflection" (Brocki & Wearden, 2006, p. 88). IPA insists that events and objects are to be understood by investigating how they are experienced and given meaning by an individual through that individual's life/world (Bramley & Eatough, 2005). IPA has been successfully applied to studies investigating people's experiences of psychosis. For example, Newton, Larkin, Melhuish and Wykes, (2007) attempted to determine young people's experiences of group psychological therapy for auditory hallucinations. They discussed two main themes that emerged including an experiential account of the group and the cyclical relationship between the content of voices, the participants' explanations and reactions to the voices and how they coped with them. Furthermore Knight, Wykes and Hayward (2003) reported themes of judgement, comparisons and personal understandings of mental health issues when investigating stigma in schizophrenia using an IPA approach. In their study on hearing voices and IPA, Knudson and Coyle (2002) demonstrated the potential for voice hearing to be particularly traumatic ("*...He (voice) is real to me because I hear it and it's disturbing*" and "*...And then I got a really loud voice, which was very scary...It had quite an angry tone to it. Yeah...it was quite nasty*"). One of the difficulties in using qualitative methods is the resulting small sample sizes, lack of scientific rigour and inability to generalise to the wider society. However, it is also important to consider the experience of the person as a whole, rather than taking a reductionist perspective as most quantitative research does. Furthermore, most research into trauma and psychosis generally uses self-report questionnaires, which have been criticised due to the reliability of measuring experiences in this way. As the experience of the person is important in the growth literature, it is for this reason that IPA will be used.

Participants and recruitment.

As the present study used interviews and subsequently analysed the transcripts and themes using IPA, a sample size of seven was considered appropriate. This was in line with Smith and Osborn's (2003) suggestion that five or six participants are sufficient for an IPA study given the lengthy process of analysis. According to Smith (1996), small sample sizes are the norm in IPA studies due to its commitment to "*painstaking analysis*" (p. 56) and the idiographic mode of inquiry. Smith and Osborn (2003) also report that "*a distinctive feature of IPA is its commitment to a detailed interpretative account of the cases included and many researchers are recognising that this can only be realistically done on a very small sample ... one is sacrificing breadth for depth*" (p. 56). In addition, Brocki and Wearden (2006) stated that IPA studies "*tend to be more concerned with examining divergence and convergence in smaller samples*" (p. 95) and that in qualitative research, it is always possible that the next interview "*might be the one to produce confounding evidence and it is therefore important that researchers acknowledge limits to the representational nature of their data*" (p. 95) rather than aiming for saturation. More recently, Smith, Flowers and Larkin (2009) have given the range for interviews of between four and ten for doctoral projects. Overall, the recruitment of participants took 8 months in total.

Six of the participants were recruited from a national charitable organisation that has groups running throughout the UK. Of these six participants, three were recruited from a support group based in Yorkshire, two were recruited from a group based in Lincolnshire and one was recruited from a group in Leicestershire. The final participant was recruited from a locally run support group in Nottinghamshire, which is unrelated to the national charitable organisation.

Participants completed demographic information for the study (see Appendix one). This included: age, gender, residence (closest city), religious beliefs, relationship status, employment status, whether they have had a formal diagnosis of psychosis or whether they have experienced symptoms suggestive of psychosis, whether they are currently engaged in treatment (pharmacological or otherwise) for their psychosis and if they feel their experience of psychosis has been traumatic. There were a number of reasons that this information was collected. Firstly, the information helped provide generic information to identify the sample of participants. Secondly, certain information also ensured that participants met the inclusion criteria for the study. Finally, certain demographics (e.g. social support, religious beliefs and employment status) have been identified as helping to protect people from trauma or helping to promote recovery of psychosis (Silverstein & Bellack, 2008). As a result, these were considered to be important information to collect from participants.

The lead researcher was invited along to attend a support group session to discuss the present study with members of the group. This took place either at the start or the end of the group forum and anyone who was interested in taking part in the study was asked to approach the lead researcher at the end of the group session. At the end of the session, the lead researcher met with interested participants to discuss the study in more detail. It was at this time that the researcher screened potential participants to ensure they met the remaining inclusion criteria via informal discussion.

Those group members who attended the meeting and who met the inclusion criteria were given the Participant Information Sheet (see Appendix four) to take away and read through to determine if they would like to participate. Participants were encouraged to contact the researcher via telephone or email if they would like to take part in the research. In addition, two follow-up sessions were provided to the

group over a 3 month period to meet new members and to follow-up any potential participants. During these additional sessions, the same format to recruitment was repeated as above. All participants were subsequently contacted and were invited to meet with the researcher to discuss their experiences of psychosis. A meeting was arranged at a time and place convenient for the participants. A week prior to the interviews, participants were sent the Participant Demographic Sheet (see Appendix one) to complete.

Interviews.

The main focus of the study was to explore people's experience of psychosis, trauma and growth. As previously mentioned, this is a relatively unique area of study, therefore it is important to understand in detail this specific group of people. In order to capture how participants perceived their experiences of psychosis and growth, interviews were the primary method utilised. Semi-structured interviews provide the flexibility to engage in a dialogue with participants and follow-up on any areas of importance or interest. Ideally, the interview should allow participants to discuss their experiences and structured interviews limit the ability to do this. As with all semi-structured interviews, the questions were used as a guide only. Furthermore, semi-structured interviews allow participants to be the expert on their stories (Smith & Osborn, 2003). This type of interview schedule is also iterative; therefore questions can be added in light of the interviews conducted with participants.

In relation to the interview questions, particular questions were worded to elicit both participants' negative (traumatic) experience and positive (growth) experiences to ensure that both aspects of their experiences were considered, which is highlighted as important by Linley and Joseph (2004) (see Appendix two for the interview schedule used). In fact, Frazier, Conlon and Glaser (2001) have also highlighted

how research within the field has primarily focussed on PTG without assessing the negative changes that can also occur. By neglecting the negative effects occurring alongside the positive effects, the current literature gives a distorted picture of the findings. In fact, the studies that have considered both factors found that those who identified both positive and negative life changes as a result of their illness were the best adjusted (Cheng, Wong & Tsang, 2006; Collins, Taylor & Skokan, 1990). The interview schedule devised for the present study addresses these concerns. The interview schedule also followed a similar format outlined by Smith and Osborn (2003). By commencing with a general, open-ended question, this meant that the researcher was not influencing the direction of the interview too much, but allowing participants to start where they felt comfortable and to guide the direction of their interview. The remaining questions were open ended and non-directive so as not to influence the possible emerging themes and due to the type of interview conducted, not all of the questions were asked to participants, depending on the material discussed in the interview. Furthermore, the interview was not a linear process, allowing the researcher to follow-up on points discussed. Due to the format of the interviews, participants were not asked directly about personal experiences which they had not already introduced themselves.

At the end of the interviews, participants were asked if they wanted a copy of the transcript for their records, which was subsequently sent to those who wanted a copy. All participants received a thank you letter and a copy of their consent form for their records (see Appendix five for consent form used in the study and Appendix six for a copy of the thank you letter).

Analysis.

Yardley (2000) reports that the main reason for adopting qualitative research is due to the recognition that, "*our knowledge and experience of the world cannot consist of an objective appraisal of some external reality, but is profoundly shaped by our subjective and cultural perspective, and by our conversations and activities*" (p. 217). The present study employed a qualitative methodology utilising IPA, of which the theoretical foundations were developed by Jonathon Smith (see Smith, 1996 p. 263 for an overview). An idiographic approach to analysis, IPA is concerned with the exploration of unique individual experiences, rather than seeking to make general or universal statements (Wilbram, Kellett & Beail, 2008). IPA was therefore used to determine the participants' experiences as they present themselves to consciousness, without recourse to theory, deduction, or assumptions from other disciplines.

IPA was chosen over other qualitative methods (e.g. grounded theory, narrative analysis & discourse analysis) due to the way that IPA assesses participants' experiences, understandings, perceptions and views, therefore lending a strong focus on the individual. IPA investigates what it is like to live through individual experiences and the aim is to understand what an experience means for the person who has had this experience (Moustakas, 1994). In relation to psychosis and growth, these concepts do not exist independently of human consciousness and experience, therefore they need to be understood in relation to those who have experienced and interpreted them, demonstrating the importance of understanding the meanings of experience. Furthermore, the researcher's critical realist epistemological position favoured IPA over discourse analysis, which takes a more social constructivist approach, and grounded theory, which has been said to resemble both an interpretative and a scientific realist framework (Madill, Jordon & Shirley, 2000; Willig, 2001 - see

extended discussion for more information on this). The present study also aims to understand and make sense of people's experiences of change following psychosis, rather than develop a theory of a particular area as is evident in grounded theory. There are also a number of differences between IPA and grounded theory, namely in relation to sampling; the aim of IPA is to select participants in order to highlight a particular research question and to develop a full and interesting interpretation of the data, whereas grounded theory uses theoretical sampling, which aims to keep collecting data in light of the analysis that has already taken place, until no new themes are emerging (Brocki & Wearden, 2006). As the concept of growth is still developing and research is continuing to conceptualise it, it was difficult to determine when saturation would be evident in the present sample. Furthermore, according to Willig (2001), IPA differs from grounded theory in its suitability for understanding personal experiences as opposed to social processes. As growth is considered a personal experience and may not be the same for everyone, IPA was deemed the most suitable method to use.

Validation methods.

Qualitative methods are usually criticised for their inability to measure up to the scientific rigour of quantitative research (such as being able to generalise findings, employ a large representative sample, using reliable and valid measures to generate reliable and replicable outcomes - Yardley, 2000). However, one of the key points when considering the validity of qualitative methods is that it should not simply be compared against 'traditional' quantitative methods of reliability due to the differing epistemological positions, such as the concept of 'reality' (Yardley, 2000). In fact, Elliott, Fischer and Rennie (1999) point out that, "*the dispute about the credibility of qualitative research can be traced to its being embedded in a philosophy of knowledge development that differs from the philosophy supporting the*

quantitative, or 'received', approach to knowledge development in the social sciences" (p. 217) (see extended discussion for further discussion on the philosophy of IPA and the epistemological stance of the present research). Furthermore, qualitative research cannot be measured according to these principles, due to the inability to engage with large amounts of data in a detailed, explorative way. Due to the interpretative nature of qualitative research methods, measuring standards against the reliability and replicability of the study does not fit with these traditions, as interpretations will always be one person's understanding of reality therefore another person's interpretations of a study may yield different findings. Qualitative researchers have subsequently rejected the problems and traditions of the quantitative paradigm (Yanchar, 2006). A number of guidelines have, therefore, been developed for measuring the quality of qualitative research. For example, Yardley (2000) devised a number of dimensions of validity, on which studies using qualitative methods can be assessed against, including: 1) sensitivity to context (focussing on the philosophy of the approach, relevant literature, participants' perspectives and ethical issues), 2) commitment and rigour (in-depth engagement of the topic, immersion in the data), 3) transparency and coherence (transparent methods and data presentation/analysis, reflexivity), and 4) impact and importance (e.g. enriching knowledge and understanding, practical implications). In addition, Elliott et al (1999) considered a number of publishable guidelines pertinent to qualitative research, including: owning one's perspective, situating the sample, grounding in example, providing credibility checks, coherence, accomplishing general vs. specific research tasks and resonating with readers. The study considered a number of these guidelines. An accurate description of the participants was collated via demographic information sheets as outlined earlier. The main researcher also considered her epistemological position in relation to the present study, which can be

found in the extended discussion section. The present study also employed the following validation methods:

Triangulation.

The researcher plays a dynamic role within an interview situation (Brocki & Wearden, 2006). In order to ensure that the outcome of the interview was not overly influenced by the main researcher, it was important that the subject area was viewed from differing perspectives. This also enables the study to be considered in more detail and ensures a multifaceted account of the phenomenon being studied (Smith et al, 2009). As a result, triangulation was used at numerous points throughout the present study, including the devising of the interview schedule and during the analysis of the interviews and subsequent coding of themes. During development of the interview schedule, a clinical psychologist independent from the research, along with a researcher who was involved with the study, ensured that the questions were appropriate for the participants and did not include leading questions. For the analysis of the interviews and coding of themes, a researcher linked with the current study independently checked the transcripts and developed the themes and these were compared with those of the lead researcher. According to Smith & Osborn (2003), triangulating the perspectives of different researchers can enrich the analysis. However, it is worth acknowledging that the concept of triangulation could be seen as seeking 'truth' within participants' accounts (Ponterotto, 2005). The present study is not seeking a true 'reality', so rather than investigating whether interpretations are correct, the use of triangulation in the present study was primarily concerned with ensuring the themes and interpretations fit with the original account provided by participants. Furthermore, participants were selected from a number of differing organisations to ensure some diversity of experience and understanding rather than purely being influenced by one particular organisation. Participants also reflected multiple age

groups with a variety of different experiences and time intervals since diagnosis.

Data comparison.

The researcher is involved in a process of double hermeneutics when interpreting the information provided by the participants (see theoretical underpinnings and epistemological stance section). Furthermore, the researcher is not passive within the research process, as they also bring their own preconceptions and beliefs to their analysis of the interview data. To ensure that the coding of the data and the emerging themes were reliable and not unduly biased by the researcher, data comparisons between the main researcher and the second author were used as a way of comparing the emerging themes. As described above, this process involved both researchers independently checking the transcripts of each participant and coding the emerging themes, which were then compared and contrasted across the participant group. The researchers then met to compare their codings and themes and a final group of superordinate and subordinate themes were developed.

Transparency.

In order to ensure that the research process was transparent, the lead researcher kept a reflective diary. This documented the relevant thoughts and feelings of the researcher during the process of the research. This included documenting and bracketing any pre-conceived thoughts or ideas prior to interviews and reflections on the process of interview after and during transcription. The reflective diary allowed the researcher to document anything which was considered relevant in understanding the process of the research and allowed the researcher space to record significant thoughts or ideas. Many of these reflections are documented throughout the analysis and discussion sections. Furthermore, to ensure transparency of the themes, examples and quotes were taken from participants interviews to

demonstrate that the themes are grounded in the data and are meaningful and coherent (Elliott et al, 1999). All interviews were also audio-recorded to ensure that the accuracy of people's stories could be reproduced and this allows other auditors to ensure the stories are a true representation of the participants' who were involved.

Audit trail.

During analysis, an 'audit trail' was collated to ensure that the correct procedures were followed and to ensure a further level of transparency with the data analysis. As each transcript was analysed, the descriptions and interpretations were noted and a complete set of emerging themes was developed. These themes were added to during the analysis of all scripts and when completed, were compiled and grouped to reduce the data and produce the subordinate and superordinate themes. This ensures the process of analysis can be followed and replicated and ensures transparency of findings. This method of validation allows an auditor to retrace all stages of the analysis (Yardley, 2008).

Ethical considerations.

There were a number of ethical considerations associated with this study. Although the study looked primarily at posttraumatic growth, this needed to be considered in the context of the whole of a person's experiences or what they considered to be important in aiding their understanding of their experiences. As a result, the study discussed with all participants the difficult and traumatic experiences that they had prior to any positive experiences. This created the potential for participants to be re-traumatised by discussing and focussing on these experiences. As the main focus of the study was to explore the participants journey to development and growth, it was anticipated that the potential for this to happen would be minimal. However, to ensure that the risk of re-traumatisation was minimised, the direction of the

interview was determined by all the participants, so they were not asked by the interviewer to talk about any material that they had not discussed during the interview or had not introduced themselves. When participants did introduce sensitive topics, the interviewer used minimal encouragement to help participants discuss this and all participants were informed prior to the interview that they were not obliged to answer any questions which they found uncomfortable or distressing. At the end of the interview, all participants were debriefed – they were asked how they felt during the interview and were encouraged to explore their feelings about discussing their story.

In addition, as participants were recruited from support groups/networks, it was initially unclear whether these participants had any additional support in the form of other treatments available (pharmacological or psychological), professional involvement (e.g. GP, CPN's psychologists, support workers) or support from their families. Because of this, the lead researcher discussed with the group facilitators about the possible need for additional support for their members after the interviews had taken place, regardless of their current support network. A plan was also developed prior to starting the research whereby anyone experiencing distress would be re-directed to speak to their GP's, if participants experienced an increased amount of distress, the interview would be terminated and a letter would be sent to their GP with consent from the participants regarding their difficulties and finally, if anyone experienced a significant amount of distress, the interview would also be terminated and they would be referred to their local mental health service. Although no such issues arose during the study, some participants did discuss difficult and distressing subjects during the interviews and we had discussions regarding their plans following the interview and whether they had any existing support available to them if they needed it.

One further ethical consideration concerned the classification of participants' mental health problems. Due to the epistemological stance of the present research, it was not the intention of the researcher to make a diagnosis of psychosis in the participants, nor to classify whether any participants had experienced PTSD due to their experiences. The aim of the present study was not to deal in matter-of-fact or prove that a person's particular experience was accurate and valid. Rather it was to develop a dialogue around participants' descriptions, perceptions and understandings of their experiences and what they bring to consciousness, as Moustakas (1994) reported "*the only thing we know for certain is that which appears before us in consciousness and that very fact is a guarantee of its objectivity*" (p. 45). In fact, in studies of growth, it is documented that it is not the traumatic event itself that is important, but what the client subsequently experiences from this event (Woodward & Joseph, 2003), therefore a clinical diagnosis of either disorder was not considered necessary during this study.

Finally, vicarious traumatisation also needed to be considered in this study. As the main researcher was interviewing participants regarding their traumatic experiences of psychosis, it was expected that the content would at times be distressing for the researcher. This was indeed the case and the main researcher considered a number of ways to reduce the effects of this, including discussions with the second author and research supervisor and more general ways of self-care, including utilising her own support networks whilst remaining confidential at all times.

Extended Results

The following provides an extended account of the themes identified in the current research. The following discusses the two superordinate themes of 1) barriers to change and 2) the adapting self and describes the subordinate themes within these:

1) Barriers to Change

Upon describing their journey to date, many participants reported a number of difficulties along the way to change. These difficulties appeared to represent a number of obstructions to moving forward towards positive change and included: a) mental health system, b) impact of psychosis, and c) stigma/rejection. Details of each are provided below:

1a) Mental health system.

Six participants described the mental health system unfavourably. There appeared to be a number of reasons for this, from the impact of diagnosis and the loss of hope instilled, to the difficulties experienced with hospitalisation.

The theme of diagnosis was apparent in some stories told by participants. They described how through being diagnosed on the schizophrenia spectrum, they lost sense of who they were, resulting in worsening of their symptoms and making change much harder:

*“...this way of analysing and diagnosing someone doesn’t take into account the possibility of the individual, meaning that everybody is different and to blanketly diagnose someone doesn’t cover anything at all about their personality”
(Beth, 3)*

Beth communicates a clear message; that the system fails to take into account the ‘individual’. This somehow implies that Beth feels

that through diagnosis, parts of her personality (and her sense of self) becomes lost and are replaced by a diagnostic label. This demonstrates the sense that diagnosis is unhelpful and in some way takes something important away from people, making it more difficult to recover. This early loss of self is replaced by feelings of defectiveness or a feeling that there is something wrong with them:

“because it’s like saying there’s something so wrong with you we refused to respect that there is a cause and effect to your condition now and actually, it’s all your fault anyway (1) and by the way, socially and for the rest of your life, you’ll never going to be alright” (Beth, 5)

Beth clearly articulates her feelings regarding psychiatric diagnosis. She reflects on the feeling that she is to blame for her presentation and that diagnosis disregards the social and environmental nature of her mental health. Her use of the word ‘respect’ in this sentence portrays the feeling that she has somehow lost respect from others due to her diagnosis. There is also a sense that Beth feels a loss of hope due to her diagnosis and there is a feeling of a loss of future; that things will never get better. It also reinforces previous beliefs that psychosis is untreatable and that it is a lifelong debilitating illness and can result in people staying in the mental health system longer than necessary, as demonstrated by Eddie:

“The reason I wasn’t trying was I’d been told I’ll never ever work again... I had nothing to recover for” (Eddie, 128/130)

Eddie further portrays the loss of hope that is instilled upon entering the mental health system. It also indicates how he subsequently ‘gave up’ and stopped trying to improve or progress.

Being hospitalised was also a difficult experience for most participants and for some, this was considered unhelpful. This is

reflected by Adam, leading to his symptoms worsening upon leaving hospital and having to re-adjust to life:

“and going into hospital, that’s frightening as well... going in hospital it’s not a nice place, it’s not done up nice, it’s an un-clean place, people are ill on the wards...I was in there two maybe three weeks at a time, and then after that it’s like a nervous breakdown, getting used to life again...it seems to have took me a long time to get used to reality again” (Adam, 118)

This mirrors other participants’ perspectives that hospital can actually be more harmful for people than good, resulting in people feeling worse and hindering progress. It also indicates that hospitalisation for most people is understandably a very frightening experience. This is illustrated with the way both the system and the staff within this can re-trigger previous traumatic memories. This occurred for some participants and left them reliving experiences of past abuse and worsening many of their symptoms. For others, the coercive nature of the service made them feel worse:

“...the other negative erm thing (1) it’s not really having psychosis, it’s really of entering the services because, erm the mental health services took away every single bit of my control that I had over my life. They made me feel abnormal erm even though I’m not, they made, they made it worse...erm (1) the medication has taken away a huge chunk of my life...” (Cathy, 126/128)

This idea that entering the mental health service makes people worse was echoed by many participants. Furthermore, the idea of being controlled and coerced was prominent, with participants contemplating the lost aspect of their lives, through the structure and function of the mental health system. The way Cathy described how

the services took away 'a huge chunk of her life' reflects the idea of lost time and gives a sense of restricting progress and preventing her from moving forward. This sentiment is also reflected in accounts by other participants:

"And she (psychiatrist) said if you don't speak to people I'll never ever let you out of here. And (1) upon all their comments I felt trapped and all this abuse kept rushing right back...and I got this (1) feeling of powerlessness" (Eddie, 116/118)

There is a sense from participants that the system prolongs previous feelings of abuse with the way they were controlled and coerced by the staff, the hospital and the medication, leaving them with a sense of powerlessness and hopelessness.

Furthermore, some participants also focussed on the role of other system-orientated agencies (namely the benefits system) in affecting the changes they made. For two of the participants, the impact of the benefit system and specifically the money they received due to their diagnosis, acted as a hindrance to making any further progress in moving forward with their lives.

"I've felt trapped by amount of money that I'm getting, (2) i.e. receive that money or go and get a job...so I've felt trapped sometimes by that, that I can't move on progress...I felt that sometimes benefits that I'm getting when I am well the few times that I have been well, has been a hindrance to moving on" (Adam, 230)

For Adam, he feels the benefits he receives are a hindrance to moving forward and progressing into work. His use of the word 'trapped' implies the feeling of being stopped or limited somehow, further reflecting the idea of a barrier to progression.

1b) Impact of psychosis.

Participants described the way their psychosis had limited their life. In particular, many participants reported how their symptoms had at times made them feel worse and resulted in difficulties making progress. For Adam, his symptoms have made him doubt his sense of self, as illustrated below:

“I’ve got doubts about my own abilities to do that, whether it’s a confidence thing or just actually getting out and doing that thing, erm, and making a change in my life” (Adam, 86)

Adam reflects his doubts about himself and his abilities and demonstrates how this impacts on his inner world and motivation to change. There is a sense that Adam is struggling to accept who he is, due to his lost confidence. This loss of confidence due to his psychosis was critical in Adam’s story, in limiting his ability to move forward.

For one participant in particular, the voices that he hears have such a negative impact and a significant amount of control that it limits his quality of life:

“It affects it terribly. I can’t err go out ‘cos they said they’re forever wanting me to kill somebody” (Derek, 143)

Derek considers the impact that his symptoms have on his life. There is a sense from Derek that he feels limited or restricted by the voices he hears and that life is no longer the same as before, that it is now worse. It implies a sense of lost hope for the future.

For some participants, the barrier that their psychotic symptoms cause continued to make things worse and make changes difficult:

“I don’t think I’ve got it in me to change, I think I’ve been that used to this way of life, I don’t believe I’ve got it in me to change” (Adam, 210)

“...he’s always chirpy and laughing and joking but as the times gone on the voices and everything it’s from his y’know the toll it’s caved hasn’t it?” (Derek’s wife, 287)

Derek’s wife seems to indicate how he has become worn-down by the psychotic symptoms and how this has changed him. It reflects the feeling that he has given up hope that things can improve. Adam appears to be implying that change is difficult, if not impossible. Adam seems to fear change, possibly due to a feeling that he will be disappointed. Because of this, there is a sense that this fear of change maintains the status quo. There is also the feeling of lost hope in himself and a belief that he has no control over his future. The feeling of lost hope is evident in many participants’ stories as a barrier to positive change.

In addition, psychosis has had a negative impact on the lives of participants and has either made things worse or left them feeling unable to move forward:

“so nothing’s stopped that way...just the other side of the life if y’know what I mean. Like going out together...that’s what we miss...y’know we used to have such a lot of fun. The laughs and things” (Derek’s wife, 242-248)

“So I don’t really look to the future I always look at the past though and sometimes I say to myself how can I improve on the past...Sometimes I feel I do and there are other times I’ll be thinking about it and I’ll be thinking I should have gone on a bit further than what I’m doing now I’m no good, I’m no better now than I was a year ago” (Gary, 130)

For Derek and his wife, there is the sense that the good things in life have ‘stopped’ and it demonstrates the grief for this lost part of their life. Gary implies that he has become ‘stuck’ in his life. There is also a

sense that Gary is self-critical about the progress he has made and indicates that having high expectations for change may be unhelpful in implementing these changes and moving forward. Therefore people's internal perceptions of progress may be unrealistic and result in limiting progress.

1c) Stigma/rejection.

The relationship that the participants had with society was strained due to the way that society stigmatises people with mental health problems:

“a lot of the time I've got to say to myself I'm never going to get back to work 'cos there's a lot of discrimination out there and what do you tell somebody you've done in the last 13 years?” (Gary, 116)

Gary contemplates the stigma he will receive when he tries to find work and considers this as a barrier to finding employment and moving forward. For Gary, this reflects a feeling that he will never progress and achieve the 'normality' of integrating back into society. His description of 'out there' demonstrates the idea of society as being separate to himself. It also reflects a sense of a lost future, as though he has given up on the possibility of getting better.

Many participants also discussed the feeling of being rejected by society and the subsequent negative impact this had on their sense of self:

“how I see myself, erm, (3) to other people to friends I can only describe myself with friends and as I've talked about that deep thinking a lot of time and not being light hearted, erm, (2) am I different from them, I've been told I'm different by them and I suppose that's been another barrier that's been

put up that's made me feel more isolated more lonely” (Adam, 182)

Adam discusses how he sees himself in relation to others. He describes comparing himself to others who do not have psychosis. The way this is worded implies that he cannot consider himself in isolation, as though he is unsure of whom he is, unless it is within the context of others. It also reflects the difficulty for people with psychotic symptoms trying to integrate into society when they are constantly seen as different and feel a sense of rejection. This further impacts on their psychological wellbeing and sense of who they are. For this particular participant, there was also the sense that he wanted to integrate into society but there were barriers to achieving this. By describing this as ‘another barrier’, Adam implies that there have been other barriers to change.

Summary of theme 1.

Participants recounted a number of barriers within their stories on their journey towards positive change. For most participants, they experienced a number of difficulties upon entering the mental health system. For many, the barriers to change came from their loss of individuality, a lost sense of self and feelings of defectiveness and for others it created a life-style which acted as a hindrance to moving forward. Importantly, the loss of hope that the mental health system instilled left many participants with no drive to move forward. The impact of their psychosis was also apparent in creating a number of barriers to change, including greater comorbidity with other psychological problems, their psychotic symptoms as re-traumatising, lost time due to their psychosis and limiting their quality of life. Finally, participants also reflected on how they were stigmatised by others, leaving them feeling unable to integrate into society and thus finding it difficult to move forward.

2) The Adapting Self

A number of different mechanisms for positive change were evident in people's stories: Four subordinate themes were evident, including a) finding meaning and purpose, b) support and understanding, c) inner strength and determination, and d) self-acceptance and awareness. These are outlined below:

2a) Finding Meaning and Purpose.

Most participants strived to find the meaning and purpose behind their experiences. Those participants who struggled to engage in this process demonstrated less positive changes whereas for those who engaged with this subject, this proved to be an important process in moving towards recovery and growth. For Beth, the process of making sense of her experiences included learning from the negatives and using this to help her move forward.

"So those were two voices from my family and I looked at them and learnt" (Beth, 119)

For other participants, it included trying to understand the origin of their psychotic symptoms:

"cos most people my parents thought oh it's only y'know an imaginary friend y'know erm, it wasn't erm and it stemmed from abuse in my childhood, but I can't remember most of the abuse erm when I was little but that's obviously where it stemmed from erm and it's when I first started school" (Cathy, 20)

"so yeah I've no idea, no idea why I've had psychosis, whether it was because, through growing up and whether it's to do with childhood..., or I could say that life is a struggle and that it's obstacles that I've had to get over to learn through

life, so if I think that, that sits easier with me, that it's like obstacles that have been put there to overcome, it could be that" (Adam, 176)

For most participants, they acknowledged that their psychotic symptoms started after a significant event in their life, usually one that was distressing or traumatic. Participants were not explicitly asked about their traumatic experiences during the interview, as all participants spontaneously discussed something traumatic in their history. This reflects the importance of their early traumatic experiences for the participants and how they have linked their subsequent psychotic presentation with their early traumas. For four participants, there was the belief that their symptoms started as a result of childhood sexual abuse. For others, they believed their symptoms followed a period of prolonged drug use, although this was not always clear as in Adam's case. Making sense of his experiences was a dominant theme in his story and the above quote reflects a deeper understanding of why he started with psychosis. The use of the word 'obstacles' indicates the way psychosis has been a challenge in his life; something which has somehow stopped his life. Adam appears to be trying to discover the positive interpretations for this, seeing it as part of life that has been sent to 'test' him and implies that he believes psychosis is something which can be overcome.

Many participants used their psychotic symptoms to try and understand the meaning and purpose behind them:

"...or I'm insecure about whatever; they come out in different, different ways. But if I can, it's not as obvious as that but when I can, if I can find out why erm they might be angry or upset or distressed or erm saying what their saying erm, they tend to dissipate" (Cathy, 100)

Cathy communicates the importance of listening to and understanding the voices. She acknowledges that the meaning is not always clear and describes searching for an understanding, which typically results in reduced symptom presentation. Beth describes a similar process in how the symptoms she experiences influence her life:

“the smelling of...the smell of piss for me (2) is not a trigger it’s a warning sign, yeah its warning me that there’s stuff going on that I need either to withdraw from certain situations or take timeout or to have a closer look about what’s going on in my life” (Beth, 43)

Beth describes the way she relies on her senses to understand her triggers and warning signs. She links this to her understanding of the smells in her past and what this means to her and is able to use this as a way to change her behaviour or contemplate her life in order to protect herself from becoming unwell. For Eddie, by understanding the content of the voices, he was able to understand the reasons for having them in helping him to deal with and move on from his abusive past:

“So the voices were trying to be helpful so they, they’re really really positive in that respect ‘cos I don’t perceive them as all negative. Don’t get me wrong there are some bad times when they say some really horrible things (1) but er, again if I really explore what they’re saying they are there, they are there for a reason” (Eddie, 180)

Eddie conveys the sense that he is now comfortable with the presence of the voices, as he has developed a better understanding of them. He also demonstrates the shift in his position from previously ignoring the voices and trying to shut them out, to listening to and learning from them and viewing them positively.

Many participants described aspects of their experiences which were indicative of psychological growth. Participants described learning from the negative side of their experiences to engender a positive outlook on life. This included participants re-evaluating their lives at present compared to how they were before:

“yeah it was all quite negative but I look back and think well (1) you know (2) would I still be at home now doing drugs if we hadn’t fallen out or what I could have died from overdose my life could have been hell of a lot worse than what it is now so I do turn that around” (Frank, 136)

Frank portrays the process of re-evaluating his life based on his experiences. This involves retrospective contemplation of his life and ‘what if’ scenarios. For Frank, putting his life in perspective was an important driving force for moving forward.

2b) Support and Understanding.

All participants recognised the supportive role of key members of staff within the mental health system who had significantly aided them on their journey towards positive change. One commonality between these workers tended to be that they instilled hope and they engendered a sense of understanding and compassion:

“I got a very good worker after about six years in the system er called ‘S’ (name) she was an occupational therapist and she was like a breath of fresh air...Because she never ever treat my diagnosis...what she did she just looked beyond it she said y’know you’re names ‘E’ you’re not a schizophrenic...she also told me a bit about herself what stresses and pressures she’d had in her life and I thought wow this woman does understand (1) ‘cos I’d always seen workers as robots with no feelings and emotions like and er

she was so kind to me and she helped me resolve the problems” (Eddie, 62/64/66)

For Eddie, the feeling of being understood was important for him to make a connection to someone. Eddie's perception of previous workers as 'robots' portrays a sense of rigidity, of someone who is mechanical, cold and unfeeling, compared with the humanity displayed by the current worker who provided “*a breath of fresh air*”. On one level, this displays a shift in Eddie's perceptions of the mental health system with the way it has been challenged by one key person. It also indicates that the worker focussed on him as an individual rather than focussing on the diagnosis. It implies that this was the first time this had happened to Eddie and possibly indicates the start of him re-defining himself.

Voluntary services also played a role in supporting participants. For all participants who described this, they reported finding these experiences enjoyable along with providing a greater social outlet ((referring to group) “*it's quite good actually*” (Derek, 411)).

Participants also described how other individuals with mental health problems had a positive impact on their lives:

“she's a manager down in (city), part of the mental health trust down there...she's also a service user, she has manic depression she uses her own services when she's unwell and she is an inspiration” (Cathy, 216)

Cathy appears to demonstrate how someone with mental health problems can continue to function within society and this 'inspires' others to achieve the same. It reflects the idea that role models can influence others for the better, inspiring them to progress and strive for positive change.

There was also a sense that participants had developed a greater understanding of others through becoming more empathic and by relating to others:

“I’m more tolerant of other people, I can sympathise with other people whereas before, before I was ill and that, I didn’t sympathise with a lot of people, yeah, life’s a bitch, tough y’know...Whereas now I’m a lot more kinder and a lot more sympathetic to people, a lot more understanding” (Gary, 86/88)

“I find myself less and less just seeing people as they are, yeah, like it’s a bit deeper than a face value thing because like it’s the sort of, it’s going to sound bizarre to you... it’s a sort of soul to soul thing” (Beth, 241/243)

For Gary, psychosis has helped him to be more tolerant of others with mental health problems. He demonstrates a greater awareness of others and demonstrates a shift in his own perceptions and ideas about what mental illness is. For Beth, this goes deeper to sensing a connection to the other person. It may also unconsciously reflect how she wants others to see her, rather than viewing her at ‘face value’ as the mental health system has. By developing this empathy and understanding for other, this had led participants towards helping others. All participants appeared to move towards agents of change; helping and supporting others with similar difficulties move forward in dealing with their experiences:

“...I’m quite happy with new people to do talking to take them to one side and find out how they’re coping and if there’s anything we can do to help them (2) but yeah (2) so yeah we set the group up in 2004 so we’ve been going 5 years” (Gary, 78)

Gary demonstrates practically how he has been helping others with their difficulties. It also indicates how Gary has been pro-active in service development. This occasionally moved beyond supporting others to inspiring others by recounting their own stories and journeys:

“When I start doing a teaching session and its erm, it’s, it’s inspired a lot of voice hearers my opening phrases and I will stand by this till the day I die. I introduce myself as “E” (name), a voice hearer. But I always say I am not just a voice hearer, I am proud to be a voice hearer... Cos they’re my experiences and I now own them, no one else owns my experiences, I own them and that’s what people should be. Stand up and be proud and own your experiences. I think that’s the way to turn a corner really” (Eddie, 252/254)

Eddie powerfully demonstrates how he inspires change in others. He depicts someone who has embraced his voices and who has accepted himself. There is also a great sense of self-belief.

2c) Inner Strength and Determination.

Whilst this was not prominent in many participants’ stories, for others there was an emerging story of how regaining control and power over their own lives was a powerful catalyst for moving forward. They described this pivotal moment in detail and how this shift of power played a significant role in the positive changes they made in their lives. For some participants, this resulted in gaining power and control back from their symptoms or their primary abuser:

“Now the demons of my past was my abuser...And I still saw her and ran away. So one day all I did was face her down in the street...And she wouldn’t look at me. And I thought this woman’s got no hold over me but as I did that the voices went very quiet” (Eddie, 142/144/146)

For Eddie, challenging his abuser as highlighted above led to him being freed from her hold over him. As a result, he describes how his symptoms diminished. It somehow implies that he has regained some control over his symptoms (particularly the voices he hears), over his past and subsequently over his life. This sentiment is reflected by Cathy:

“but one of the main things is I’ve taken control back over my life and that is the main thing that’s helped me ‘cos the services took away all control and before that erm, being abused and raped, control is taken away from you or any power that you had over your life is gone” (Cathy, 174)

Both Cathy and Eddie give good examples of how they have taken control back over their lives. Cathy reflects that this has been an important catalyst for helping her to move forward. She describes how her life has always been dominated by others and by gaining back this control; she has subsequently turned her life around.

For most participants, there is a sense of determination and a drive to move forward from their experiences:

“since having psychosis I seem to realise, which is a good point, that I’m alive today and I seem to want to be doing things a lot of time, I realise how quick time goes by and I seem to be driven to do things a lot of time, good things like play sport or go to football matches, or read a paper or phone friends up, so I’m imbued with a feeling of here and now” (Adam, 78)

Adam describes embracing his experiences and his ‘present’. There is also the feeling of being ‘alive’ as driving these positive changes. Adam gives the sense that life is purposeful and he has spent

time trying to adapt his life to make it more meaningful. Gary also describes the idea of inner strength:

“you’ve got to keep going if you let yourself go straight downhill you don’t come back up...you think why bother, why not just let everything go and say bollocks to it all (3) but I don’t, I sit there and think y’know sod it I’m gonna keep going and keep going” (Gary, 104)

Gary again demonstrates an ongoing inner conflict about change and moving forward. There is a sense that change is a difficult and lengthy process which is hard to maintain. However, Gary demonstrates self-determination and an inner drive to ‘keep going’, implying a sense of hope that there is something better than he experiences at the moment.

2d) Self-Acceptance and Awareness

This was a key theme for six of the participants and appeared pivotal in promoting positive change and growth. Four participants reflected how they viewed their symptoms as a part of their self. Furthermore, there was a greater sense of self-acceptance in these participants. These changes seemed to be the most significant in promoting psychological growth. One key element of acceptance for most participants was to accept their psychotic symptoms and their voices as a part of themselves. For most, this acceptance was fundamental in moving towards the goal of self-definition. For those who described an integrative self, there was a greater understanding of their symptoms and their identity.

“so I’ve come full circle in seeing them as part of my life and they reflect erm (2) my subconscious...my (2) inner fears, all my personal stuff y’know that nobody ever talks about” (Cathy, 98)

Cathy highlights how the voices she hears are seen as a part of her identity. There is also the sense that the voices reflect the parts of the self that are hidden, with Cathy expanding on how she believes the voices are a part of her subconscious. The passage also indicates her shift in perception, from initially viewing her symptoms as normal, to society dictating that they were abnormal, to now 'coming full circle' with her beliefs.

Many participants were inclined to adapt to their experiences and use them to change their outlook on life. For some participants, this consisted of using their negative experiences and the barriers to change to help them develop a greater understanding of themselves. Through their experience of the negatives, this enabled them to regain a perspective on life:

"I've adapted my life to work with the symptoms that I've got"
(Cathy, 148)

"I got the psychiatric unit for seven years so it took a bit of a wrong turn somewhere like y'know but I've come out of it liking who I am and that's the important thing" (Eddie, 206)

Eddie seems to use his prior experiences to put his life in perspective. He acknowledges that his life has not taken the path he expected but views the positives out of these experiences. He also implies there has been a favourable change in how he views himself.

There was a greater feeling that most participants were living alongside their symptoms rather than trying to reject or fight against them. This subsequently changed their view of their symptoms, to see these as normal, which changed their perception of themselves and their belief that they were abnormal or defective:

“Part of my recovery has been realising that I’m not mentally ill in terms of the sense of (3) that I have a chronic life long illness that is gonna disable me for life” (Beth, 7)

Beth describes developing an awareness that she does not have a debilitating disorder means that she can move forward towards a more positive outlook. There is also a sense that Beth has rejected the views of others and has moved towards embracing her own feelings and views about herself. It demonstrates a shift from being reliant on others to define who she is, to accepting her own view of herself. Developing this sense of self-awareness resulted in more positive changes:

“...learning about myself emotionally, using the anger against being told you’re fucked for life to actually find out what was good about me” (Beth, 229)

Beth contemplates how the voices have helped her to understand her emotions and how she now uses this as a way of learning about herself. It also implies that Beth has moved from viewing herself as ‘defective’ to uncovering the positive side of herself and embracing this. Beth acknowledges how her traumatic journey through the mental health system has helped her to learn about herself and her identity. It also indicates how the voices she hears have forced her to consider herself more and have pushed her towards getting her true self understood. Most participants also acknowledged that they were still changing and growing due to their experiences. It would appear then, that recovery and growth are ongoing processes as participants continue to experience symptoms and develop greater self-awareness:

“I’ve had periods of acute crisis still. I was in hospital last summer erm (1) and the, that I just see as part of who I am as well so, we all have ups and downs it’s just that mines erm, a lot greater “ (Cathy, 142)

Cathy describes how her 'ups and downs' are a part of who she is, demonstrating the idea of acceptance. It also reflects the idea that distress and growth can co-exist. This is also reflected in a final quote from Eddie:

"I always think life's a journey of discovery erm and in some ways erm (3), I need to thank the voices somehow. Because they've made me who I am...They're a part of me. I wouldn't want to go through the abuse again, but if I had a choice of someone saying to me ten years ago you can spend rest of your life out of the system and not hear voices, but you'll not be happy and you'll not know who you are, or you can have ten years of hearing voices and probably for the rest of your life but eventually you'll know who you are and you'll be happy. And I think that's the journey that I've took and they've took me on, like 'cos I could probably say erm (1) I'm probably the happiest I've ever been in my life at the moment"
(Eddie, 184/186)

For Eddie, the journey his life has taken has shaped his identity. He discusses how his experiences and the voices he hears has helped him re-discover and understand who he is and this has changed his life for the better. It gives the sense that Eddie has learnt from his negative life experiences but acknowledges that this has shaped him to who he is now. It is the change in his sense of self, in integrating and accepting his experiences, that have led to more positive changes.

Summary of theme 2.

All participants described a number of mechanisms which helped in facilitating positive change. For some participants, regaining a sense of control over their lives was central in moving forward. All participants described how a supportive other helped them move forward, which subsequently changed their own lives to be supportive and

understanding of others. For the majority of participants, working through the process of understanding and making sense of their experiences was also pivotal in facilitating positive change. Early traumatic experiences appeared to be the key component for understanding how they had come to develop psychotic experiences. Accepting these experiences and their psychotic symptoms as part of themselves seemed to be the biggest indicator of recovery and growth. Many participants went on to demonstrate a number of positive changes resembling psychological growth, including inner strength and determination, greater self-awareness, empathy and relating to others, life as purposeful and regaining perspectives on life.

Extended Discussion

The analysis of the interviews with participants demonstrated that recovery and growth are possible in people who have experienced trauma and psychosis. However, participants' experiences of the process of change following psychosis in the present study were complex and variable and involve a number of inter-relating factors. What was apparent for all participants was that the process of positive change was not linear, but consisted of a number of set-backs and challenges along the way. This is consistent with previous research into change and recovery, where participants move through a number of these stages towards integration, often revisiting a previous stage in a process of ongoing adaptation (Charmaz, 1995). The idea of change and recovery as a life journey was reflected in the current research. A number of mechanisms were present in achieving psychological growth for the majority of participants:

The Adapting Self

The present findings support the findings by Roe (2001), who identified a number of factors that help facilitate the recovery process, including generating a functional sense of self and developing purpose and meaning in life. In addition, this study reflects similar findings to those presented by Jensen and Wadkins (2007) who explored paths to recovery. The authors interviewed 20 individuals with 'serious and persistent mental illness' and found three main themes relating to a) finding acceptance and understanding of their mental illness, b) redefining their identity and preventing relapse, and c) findings ways to decrease stigma and help others.

Finding Meaning and Purpose.

Participants described learning from their experiences of psychosis and using this knowledge as a catalyst for individual change and in encouraging change in service delivery and development. Research has suggested that 'meaning making' is important in helping the person cope with distressing events (Park & Folkman, 1997). According to Park and Ai (2006), meaning making "*involves coming to see or understand the situation in a different way and reviewing and reforming one's beliefs and goals in order to regain consistency among them*" (p. 393). Studies have found a positive relationship between meaning making and growth following adversity (e.g., Calhoun, Cann, Tedeschi, & McMillan, 2000), although findings have been mixed with some studies finding no relationship (Cordova, Cunningham, Carlson & Andrykowski, 2001). This could be due to the difficulty in measuring meaning making (Park & Ai, 2006). The present study identified how the majority of participants engaged in a process of making sense of their experiences. This fits with the phenomenological view that we all have an innate, in-built capacity to construct meaning out of our experiences (Spinelli, 1989). Park and Ai (2006) reported how the

traumatic events must be processed, along with making sense of the event including emotional engagement with the trauma and re-framing of the trauma, in order for individuals to recover.

Support and Understanding.

Other factors which may have aided the process towards growth came from participants' discussion on the importance of personal support from significant others, family members or important and influential relationships. There is consistently documented evidence within the literature to support an inverse relationship between social support and PTSD (Clapp, & Beck, 2009; Ozer, Best, Lipsey & Weiss, 2003). In addition, studies into recovery in people with psychosis have implicated social support as important in aiding recovery (Norman et al, 2005). Therefore, the research would suggest that social support can act as a buffer against psychological distress and can aid recovery and growth from psychosis. The present study has also added to this body of literature and has also established the role of influential people in aiding growth. For example, most participants described one person who inspired positive change and growth through their own similar experiences. In fact, research has shown that role models who have experienced PTG have also been implicated in facilitating PTG in others (Cobb, Tedeschi, Calhoun, & Cann, 2006; Weiss, 2002). Support groups have also been shown to inadvertently facilitate positive changes in its members, even when this is not the explicit role of the group (Antoni et al, 2001). Therefore, the participants in this study may also act as role models to other people with psychosis in promoting the possibility of growth following psychosis.

Inner Strength and Determination.

The participants in the present study acknowledged the important role of regaining control over their lives. As has been demonstrated empirically in the literature, Vauth, Kleim, Wirtz and

Corrigan (2007) reported how a loss of power in people with schizophrenia resulted in increased depression and reduced quality of life. Taking back control has been highlighted as an important stage in the recovery process (Perkins, 2003). Furthermore, Joseph and Linley (2006) describe how promoting empowerment in people who have experienced adversity helps in their psychological recovery and growth. It also limits the potential for re-traumatisation, in feeling out-of-control by a dominating other.

Self-Acceptance and Awareness.

One of the most important findings in the current study was in relation to redefining/reconstructing the self and moving towards self-acceptance. This fits with the ideas of reintegration, which is evident in Joseph's (2004) assertion that:

“As the client comes more to develop a self-structure that is congruent between self and experience, they should also become more fully functioning. Congruent reintegration of self with experience is not about the client returning to his or her pre-trauma levels of functioning, but about the client going beyond his or her previous levels of functioning” (p. 108.)

This has also been found in other studies. In a qualitative study interviewing seven people in recovery from psychosis, Pitt, Kilbride, Nothard, Welford and Morrison (2007) found that rebuilding the self was an important component in facilitating the recovery process. Salick and Auerbach (2006) also conducted a qualitative study investigating adjustment and personal growth in people with a physical disability. The authors interviewed 10 participants and analysed the interviews using grounded theory. They identified integration of the trauma and expansion of the self as a key construct in the process of growth. The authors acknowledge that the themes may have unintentionally been

guided by the interview questions as a main limitation of the study. Furthermore, it is unclear if the process may differ between those experiencing a physical illness and those in the present study who were experiencing mental health problems. Nevertheless, studies investigating the difficulties that people with psychosis have indicated a greater depersonalisation and derealisation resulting in a disruption to their sense of self (Lysaker & Lysaker, 2001; Sass, 2007). The findings in the growth literature would fit with the idea that by re-integrating their sense of self and accepting their symptoms as a part of themselves, people with psychosis can move beyond their old self towards personal growth. For most participants in the present study, the move towards adaption and self-integration was the most important predictor in subsequent reports of positive change and the potential for growth. In this vein, growth following psychosis can be seen as both a process and outcome, whereby the individual is continuously adapting to challenges and moving towards an integrated sense of self. This fits with the view of growth proposed by Calhoun and Tedeschi (2004). For the participants who achieved this, there was a greater move towards psychological growth.

This notion also resembles Joseph and Linley's (2005) organismic valuing theory (OVP) of growth following adversity. Within this theory, those participants who demonstrate growth tend to accommodate to their experiences by incorporating the new trauma-related information to re-develop their assumptions of themselves, others and the world. Previous qualitative research has also demonstrated support for this model of growth (Payne, Joseph & Tudway, 2007). The majority of participants in this study highlighted the idea of accommodating to their experiences. However, whilst most participants did demonstrate aspects of positive change, for a small minority (n=2) their description of positive changes did not strongly resemble the idea of growth. In fact, there was also a larger focus on

the continuing negative aspects of their experience and the barriers which were difficult to overcome in these participants. For these participants there was a greater focus on assimilating back to their life before they developed psychosis. As a result, they discussed less positive changes and described focussing on primarily negative components of having psychosis, along with their continuing battle with their psychotic symptoms. This resembles the idea of assimilation in the OVP theory of growth. Those participants who assimilated to their experiences moved towards restoring their previously held assumptions of the self and the world, in an attempt to return to a pre-trauma/pre-psychosis state. The present study, therefore, demonstrates how re-integrating the self to accept their psychosis as part of themselves may be the most important component in facilitating growth.

Evidence for Growth and Recovery

The present findings reflect similarities with research found in both PTG and recovery literature. According to Tedeschi and Calhoun (2004), PTG is a multidimensional construct including changes in beliefs, goals, behaviours, and identity as well as the development of a life narrative and wisdom. They also report that social support variables and some enduring distress are assumed to influence the coping process and the emergence of PTG. The present study provided support for this idea that growth is multidimensional, as participants described a number a positive changes they had made which reflected the concept of psychological growth. These included feeling a greater appreciation of life, finding meaning and purpose, helping others, increased inner strength and determination, greater empathy and greater understanding and self-awareness.

This supports findings from other research into PTG. For example, in developing a measure of PTG, Tedeschi and Calhoun (1996) designed a questionnaire to measure three broad areas of

growth: perceived changes in the self, a changed sense of relationships with others, and a changed philosophy of life. The questionnaire (referred to as the posttraumatic growth inventory; PTGI) was administered to undergraduate students. Using a principal components analysis, five factors were extracted, including: appreciation of life, relating to others, new possibilities, personal strength, and spiritual change. However, one of the criticisms of the questionnaire is that it may represent cultural differences as some cross-cultural studies have failed to show support for these findings (Taku et al, 2007), although this is not always the case (e.g. Shakespeare-Finch & Copping, 2006). The present study found support for the ideas of appreciation of life, relating to others and personal strength. The latter also reflects the findings of Woodward and Joseph's (2003) study into people who had experienced childhood abuse. Their findings of a thematic analysis demonstrated the idea of an inner drive.

Linley and Joseph (2003) describe a number of changes resembling growth, including changing their life philosophy, appreciating life, greater resilience and strength, more altruistic and enhancing relationships. Many of these factors were present in the current study. The idea of appreciation of life has also been documented in many studies of posttraumatic growth (Bellizzi & Blank, 2006; Chun & Lee, 2008; Cobb, Tedeschi, Calhoun & Cann, 2006; Frazier et al, 2001).

In addition, the above findings reflect similarities within much of the psychosis and recovery research. More specifically, aspects of Andresen et al's (2003) study are reflected in the present study. The authors investigated the common themes emerging from the literature into recovery following schizophrenia and other mental health problems. They identified four component processes of recovery: 1) finding hope, 2) re-establishment of identity, 3) finding meaning in life and 4) taking responsibility for recovery. In addition, their model of recovery was based on qualitative studies and included five stages: 1) moratorium, 2)

awareness, 3) preparation, 4) rebuilding, and 5) growth, resulting in a positive sense of self. This final stage of their model was evident in the present study, including having a positive outlook on life, living a full and meaningful life, a positive sense of self and being a better person based on their experiences. Furthermore, one finding from the present study was that participants moved towards putting their life in perspective. This finding has also been demonstrated in similar studies. For example, Higginson and Mansell (2008) presented their study of change and recovery in six people with psychological problems. By using IPA, the authors found a number of themes, including hopelessness and issues of control, the change process, new self versus old self, and putting the problem into perspective. These findings indicate how participants not only demonstrated 'growth' (as defined with the trauma and PTG literature), but also demonstrated 'recovery' (as defined within the psychosis and recovery literature).

As such, it is important to consider the similarities in the present findings to both recovery and growth. There is an increased move towards a recovery-orientated approach for people with psychosis (NIMHE, 2005). According to Davidson and Roe (2007), recovery in clients with mental health problems is no longer referred to as an *outcome* to mean 'symptomatic recovery' or a pre-illness state, as this is considered impossible. Instead, recovery is seen as a process, which involves "*overcoming the effects of being a mental patient – including poverty, substandard housing, unemployment, loss of valued social roles and identity, isolation, loss of sense of self and purpose in life, and the iatrogenic effects of involuntary treatment and hospitalization – in order to retain, or resume, some degree of control over their own lives*" (p.462). In this vein, recovery does not mean cure, but emphasises that episodic symptoms can still persist. Research within trauma and growth field inadvertently supports this new definition, as Tedeschi and Calhoun (1995) report that growth often occurs in the context of highly

distressing events, meaning it may co-occur with distress. In fact, this highlights the indistinguishable overlap in definitions for the concepts of growth and recovery, with growth seen as "*a shift toward more optimal functioning as a result of the adverse experience*" (Linley & Joseph, 2005, p.263). This overlap is also evident in many research articles (e.g. Andresen et al, 2003; Jensen & Wadkins, 2007; Perry, Taylor, & Shaw, 2007). For example, Kelly and Gamble (2005) describe five main components of recovery: hope, mentorship, spirituality, being & individuality and growth, the latter of which refers to a process of self-discovery and discovering meaning and purpose. This is also supported by Andresen et al's (2003) and Bonney and Stickley's (2008) review of the psychosis and recovery findings.

The above findings point to evidence of both growth and recovery in participants in the present study. It could be that growth is one component of recovery, that growth is essential for recovery to occur, or that growth and recovery are similar processes of positive change. Either way, these findings demonstrate the importance of not forcing a distinction between the two concepts within mental health, as it has been within the trauma and growth fields. Most importantly is the finding that growth and recovery can occur in people who have experienced a traumatic psychotic episode.

Barriers to Change

Within the study, a number of barriers were identified as limiting recovery and growth in the participants. Similar findings have been found in other qualitative studies. Jensen and Wadkins (2007), in their study of recovery in 20 people with mental health problems, identified a number of barriers to recovery, which predominantly related to the mental health system and the stigma received from others.

Mental health system.

Some participants remarked on the traumatic experience of entering the mental health system, likening this experience to being abused. This lent support to Morrison et al (1999) who reported that psychiatric hospital is potentially one of the most stressful aspects of mental health problems. Jackson et al, (2004) also reported that psychotic symptoms were positively related to retrospective accounts of a stressful ward environment and the type of coping skills adopted. However, the small sample size investigated means that findings cannot be generalised. Nevertheless, these findings have also been supported in recent studies where the impact of the psychiatric inpatient setting can be perceived as a frightening and dangerous environment and thus results in traumatic experiences for individuals (Calhoun et al, 2007).

Interestingly, two participants remarked on the role that other agencies (such as the benefit system) played in limiting attempts at recovery. Whilst the role this aspect plays is not well documented within the psychosis literature, recent studies have demonstrated the impact this has on recovery. For example, Cupitt, Wolfson, Okon, Materson and Popelyuk (2009) in their study researching the recovery concept in community mental health teams described how wider external systems, such as the benefits system, can hinder recovery. However, whilst Cupitt et al (2009) acknowledge the role that systemic factors play in affecting recovery, they also reflect that this is not a unique barrier and has not prevented other service users from moving towards recovery from mental health problems. It may be that mental health services need to help facilitate the process towards positive change by educating service users and playing an active role in supporting them to find meaningful employment activities or voluntary opportunities.

The present study also indicated that a loss of hope instilled by the mental health system had a limiting effect on the participants' ability to move towards positive change. Research has suggested that finding hope following mental health problems is a key component in facilitating recovery (McCann, 2002; Pitt et al, 2007). The present findings inadvertently support this idea. The notion that people have lost hope would indicate the conditions for facilitating recovery (e.g. finding hope) are not there, making it very difficult for people to recover without its presence.

Impact of psychosis.

All participants described the distress experienced due to their psychotic symptoms. For some, this was due to a re-traumatising effect, which has been found in other studies (see Morrison et al, 2003, for a review). This also supports the research by Mason et al (2009), suggesting that the content of delusions and hallucinations are linked to previous abuse and this can produce a re-traumatising affect. For other participants who did not describe an abusive childhood, they still described the distress at having psychosis, particularly regarding the derogatory nature of the content of the voices they heard, leaving most feeling depressed and with low self-esteem. This has also been highlighted within the research (Birchwood et al, 2004; Knudson & Coyle, 2002). For example, Chisholm et al (2006) examined the content of persecutory delusions and indicated an increased perception of threat and higher trauma scores.

Stigma/rejection.

While all participants reflected on the supportive nature of relationships, they also acknowledged the negativity received from others, particularly around public stigma. It has been reported that schizophrenia is one of the most stigmatised conditions (Angermeyer & Schulze, 2001). Link, Cullen, Struening, Shrout and Dohrenwend

(1989) modified 'labelling theory' to explain stigma in mental health problems. They proposed that socialisation leads individuals to develop a set of beliefs about how people with mental health problems are treated in society. When an individual develops mental health problems, they use their pre-defined beliefs to pre-suppose they will be devalued and discriminated against and this affects their relationships with others. This results in people withdrawing, loss of social support networks and results in low self-esteem. Support has been found for this theory; anticipatory stigma, along with dysfunctional coping, results in a greater eroding of empowerment, which has been shown to increase depression and reduce quality of life (Vauth et al, 2007). Whilst the findings are evident for a link between belief in public stigma and negative effect, it fails to consider the role of direct, actual stigma. In a qualitative study investigating stigma in six people with schizophrenia, Knight et al, (2003) found evidence of public stigma, including stereotypical attitudes, prejudice and discrimination from a number of different sources including family, friends, society, police, and mental health professionals. Furthermore, a cross-sectional interview survey by Thornicroft, Brohan, Rose, Sartorius and Leese (2009) revealed high rates of both anticipated and experienced discrimination in 27 countries and 732 participants. Specific results showed negative discrimination was experienced in making or keeping friends (47%), by family members (29%), and in finding (29%) and keeping (27%) a job. Anticipatory discrimination limited participants in applying for job or vocational activities, in developing relationships and resulted in many hiding their diagnosis. The number of different sources who are highlighted as stigmatising mental illness is particularly important and these systemic factors need to be considered in relation to maintaining psychological distress and social isolation.

Trauma and Psychosis

Whilst the findings in the present study expanded on the literature of psychosis and growth, it also added to the body of knowledge focussing on the negative aspects of psychosis. Participants freely discussed previous traumatic and abusive experiences without prompting from the main investigator. This supports the belief that the methodology allowed participants to have a voice without being restricted by any preconceived ideas or leading questioning by the researcher. It also highlights how important this issue was to participants. Furthermore, whilst many participants discussed the positive changes they have made in their lives, their early traumatic experiences still remain prominent for them, demonstrating how growth and distress can co-exist.

Whilst this study did not intend to add to the literature on trauma and psychosis, it showed an apparent link between early childhood abuse and the subsequent development of psychosis with over half of the participants experiencing childhood sexual abuse. Four participants described the emotional impact the abuse had on them during childhood and the continuing impact into adulthood and all participants described their belief that their psychosis developed as a result of these early traumatic experiences. This mirrors the findings of Bak et al's (2005) longitudinal study, where the authors studied 4045 non-psychotic individuals who were either exposed or not exposed to traumatic events prior to 16 years of age. They found those participants who were exposed to a traumatic event prior to the age of 16 and who suffered increased emotional distress as a result of this were more likely to have had psychotic experiences compared with those without a trauma history. In addition, for most of these participants, they described a clear link between their early childhood experiences and the content of their hallucinations and intrusive delusions. This supports previous findings in this area, such as those by Mason et al,

(2009) whereby they reported a link between trauma (specifically childhood sexual abuse and also childhood physical abuse) and the content of hallucinations. In addition, their findings supported the idea that early trauma is relevant to negative views of the self in psychosis. However, the small number of participants in Mason et al's study (n=39) meant the study lacked statistical power. For one participant in the present study, it appeared to be the loss of innocence and disruption to the sense of self which impacted on the subsequent development of psychosis, which supports the ideas developed by Mason et al (2009).

The findings also support the idea that having psychosis can result in PTSD-like reactions. For example, most participants in the present study described how hospitalisation and entering the mental health system can be particularly traumatic, supporting previous research in this area (e.g. Frueh et al, 2005; Tarrier et al, 2007).

The findings of the present study, then, lend support to the idea that developing psychosis can either directly or indirectly result in a traumatic reaction. As proposed by Morrison et al (2003), it is important that an integrative approach is taken to this area, particularly at the early stage of assessment when entering the mental health services. As has been highlighted, PTSD regularly goes unrecognised in people with psychosis due to the overlap in symptom presentation (Chisholm et al, 2006).

Methodological Considerations

The main focus of the study was on aspects of change and growth in people with psychosis. Whilst the study acknowledges the small sample size, this is in keeping with the traditions of qualitative research, allowing a greater investigation into individuals' experiences. Therefore, it acknowledges that the findings of the study cannot be

generalised to the wider population. However, the interpretations made in this study may be useful in understanding the experience of other adults who experience psychosis but will be less applicable to adults presenting with other mental health difficulties. Furthermore, as the diagnosis of psychosis involves a number of combinations of psychotic symptoms, this study will not reflect everyone's experiences of growth and positive change following psychosis. Further research is needed into the area of growth in mental health problems.

Furthermore, whilst the study employed prospective sampling, it was difficult to recruit a homogenous sample in line with the guidelines on IPA. This is due to the complex and varied nature of psychosis. However, the present study did attempt to recruit participants who described having had a particularly traumatic experience of psychosis to ensure the intensity of their psychosis was similar, although this experience is also subjective and reliant on participants' previous life experiences. For this reason it may prove difficult to recruit a sample of participants who have experienced psychosis which would be truly homogenous.

The study employed retrospective accounts of participants' experiences. A prospective study on traumatic experience and the subsequent development of psychosis is possible. This would need to be followed by a longitudinal focus on the potential for growth within this population. However, it is anticipated that such a study would be difficult to negotiate, requiring a large sample size to control for probable participant attrition. Also, the present study was not concerned with accurately representing participants' accounts of previous traumas, but was interested in participants' interpretations of their experiences of psychosis to understand the process which may have led to posttraumatic growth. Furthermore, for most participants, their experience of psychosis and subsequent growth was an ongoing process.

It is also worth acknowledging that participants were interviewed at different time periods following trauma; one participant was interviewed 29 years after her first traumatic experience and another after over 50 years. Therefore, it is worth considering that the time that had elapsed may have affected the participant's descriptions or memory of events and generational differences may have affected how participants responded to such events both during and following the traumatic stressor. The same is true for the diagnosis of psychosis, with one participant being interviewed after 20 years and another 42 years after of the onset of psychotic symptoms. These differences in time may reflect the different stages of change and recovery that various participants discussed and the generational differences also need to be acknowledged, with younger participants possibly being influenced by the recovery movement. The study also considered a number of different trauma-related events with varying severity, including repeated traumas and single events. As has been acknowledged by Shelvin et al, (2008), multiple traumas may have an impact on more severe psychotic symptoms and result in changes in personality structure (Neria et al, 2002). This could mean that changes may have been slower and more difficult for some participants, reflecting differences in their process of change. As has also been highlighted elsewhere, different processes may be apparent in how participants adapt to these diverse experiences (Zoellner & Maercker, 2006).

Within the study, participants discussed their personal process towards positive change. Due to this, it could be considered a criticism that the study relied on participants' self-perceived growth and recovery, as many studies investigating growth have criticised the reliance on self-perceived PTG, rather than investigating objective PTG (Zoellner & Maercker, 2006). Furthermore, Calhoun and Tedeschi (2004) also present the argument that reports of PTG "*should not be taken at face*

value because they may involve some form of defensive functioning" (p. 94). However, Pals and McAdams (2004) report that "*the analysis of narrative accounts may constitute the most valid way of assessing posttraumatic growth*" (p. 65). Whilst it may have been beneficial to investigate objective growth by interviewing carers or family members of service users as undertaken in other studies (Dunkley et al, 2007), this method does not fit with the principles of IPA in exploring unique individual experiences. Whilst reflecting on phenomenology, Spinelli (1989) reports "*our judgement is influenced, to a great degree, by consensus viewpoints agreed upon by a group or individual, or by a whole culture*" (p. 5). Furthermore, the participants in the current study did not specifically discuss growth, but discussed their positive change and journey towards recovery as a result of their experiences. Therefore, it is within the content of participants' stories that growth was evident and this fit with the research on PTG and recovery.

Clinical Implications

One of the most unnerving findings is the way some participants found entering the mental health system extremely distressing. Participants described how both psychiatry and the hospital system was abusive and reflected on the feelings of lost hope for the future. This resulted in many participants feeling powerless and a loss of control over their life and symptoms, something which has been implicated in worsening psychotic symptoms and producing a worse outcome following treatment (Birchwood, 2003; Campbell & Morrison, 2007). This can lead many people with psychosis to disengage with services, leaving them more vulnerable (Mueser & Rosenberg, 2003). This clearly has implications for the clinical practice in mental health services, particularly as the feelings of coercion and lack of control may result in re-traumatisation for many people with a history of psychosis

and trauma (Morrison et al, 2003). Morrison et al proposed that mental health services should be designed with the minimisation of trauma in mind, including alternatives to hospital admission and more consideration for the effect that service delivery can have on participants with such traumatic histories. Furthermore, as the recovery concept is becoming significant in the delivery of mental health services in the UK (Department of Health, 2001; NIMHE, 2005), services should no longer presume a loss of future and limited opportunities for service users. Mental health services should be proactive in instilling hope for positive change. In fact, research exploring personal stories of recovery in people with psychosis report that hope is a crucial component for recovery, with feelings of hopelessness associated with increased depression and worsening of symptoms (Perry, Taylor & Shaw, 2007; Repper & Perkins, 2003). Two main strategies have been devised for uncovering hope within service users, including enhancing motivation and developing pathways to wellness (McCann, 2002). Furthermore, services should also play a role in empowering service users. As was demonstrated within the present study, some participants started developing positive changes when they had regained control over their own lives; for two participants this was pivotal in their stories of facilitating growth. This mirrors findings in areas pertinent to psychosis and recovery (Perkins, 2003) and growth (Joseph & Linley, 2006). The recent National Institute of Health and Clinical Excellence (NICE) guidelines (2009) suggest a greater focus on long-term recovery and promoting people's choices about the management of their condition. The present study would welcome changes in service delivery to reflect this. McCann and Clark (2004) have also suggested that services should move towards fostering self-control and self-determinism in service users. Such examples could include initiating advanced directives to empower service users and help them regain control over decision making (Roe, Yanos & Lysaker, 2006) and involving service users with the care programme approach (Pitt et al, 2007), both of

which have been highlighted in the recent NICE guidelines for schizophrenia (2009).

The results also highlighted how stigma still remains a key challenge for most people with psychosis. As Davidson and Roe (2007) point out, "*most communities do little to educate people about the nature and prevalence of mental illness...As a result, most families are unprepared for the onset of a mental illness in one of their loved ones, and have no idea what is happening to them when they first begin to have difficulty*" (p.468). This lack of understanding by families and the wider community can lead to increased stigma and avoidance. Research by Thornicroft et al (2009) suggests that stigma limits quality of life by reducing opportunities for employment and peer/romantic relationships, both of which have been shown to be key factors in promoting recovery through empowerment and hope (Lieberman & Kopelowicz, 2005; Norman et al, 2005). This can result in low self-esteem and increased depression (Vauth et al, 2007), eventually resulting in greater challenges for mental health services, with a greater presentation of co-morbid mental health problems and increasingly complex intra-and-interpersonal difficulties. Mental health services need to focus more on preventive strategies and tackling maintenance problems. This should include challenging the stigma and preconceptions of psychosis in individual clients, family members, communities and wider society, if recovery and growth are to be achieved in their clients' lives.

The findings of the present study indicate the potential for psychological growth and recovery in people with traumatic experiences and psychosis. Key factors in facilitating growth and recovery included finding meaning and purpose, inner strength, self-acceptance and integration and support and understanding both from and to others. However, recovery and growth was an individual process for many participants, with no two people demonstrating a uniform process for

the positive changes they made. For some, the process occurred much sooner than others, and all participants reflected that some level of distress and episodic mental health symptoms remained even during their recovery. This is important for any therapeutic work with people presenting with psychosis and trauma. Clinicians should use this knowledge to explore with clients what their personal views of recovery are, to use psycho-education to promote the potential for recovery and to plan individual care pathways to facilitate this. Services should increase hope, promote understanding and self-discovery and allow for clients to explore their own experiences of positive change. However, this needs to be a fine balance between promoting recovery and imposing unrealistic expectations on clients. Services need to be open to new possibilities for individuals' personal recovery.

Future Research

One of the main difficulties in the literature on growth and recovery is due to the limited ability to draw conclusions from the data. For example, virtually all studies have assessed growth and trauma at one point in time (typically using retrospective accounts) therefore it is hard to conclude whether early or later reports of growth and recovery result in changes to distress levels over time. Therefore, a longitudinal study of this nature assessing changes intermittently from the point of diagnosis would be helpful in assessing the progress of recovery and psychological growth.

Future studies may wish to consider the findings of the present study and determine if the factors identified in aiding recovery and growth (such as finding meaning and purpose, self-acceptance, developing understanding and empathy and achieving inner strength and determination) can be found in other client groups (e.g. people with PTSD, depression and anxiety). This is due to the way the current

trauma and PTG literature has demonstrated mixed findings for the potential for growth in people with a range of mental health problems (see Park & Helgeson, 2006, for a review). However, it is possible that by focussing on growth (as different to recovery), the studies are missing important information relating to recovery in mental health difficulties. It could be that by applying a flexible model, which considers recovery and growth as interchangeable, may produce more favourable findings. Furthermore, future studies may also move towards testing the concepts of growth and recovery with a larger group of participants who have experienced psychosis using quantitative methods. This would help studies to generalise the findings to a larger group of people.

Future research may also benefit from exploring the concepts of recovery and growth from professionals within the mental health field. This would be particularly pertinent in exploring how recovery is currently being facilitated by mental health professionals and across teams. It would also be helpful to explore professionals' opinions regarding whether mental health services (such as accommodation, hospitals, vocational and occupational activities) are equipped to deal with engendering recovery in their clients and how best services can adapt to this.

Clinical Relevance

The research is clinically relevant as it serves to enhance our knowledge of the processes towards change and the potential for psychological growth and recovery in people with psychotic symptoms. It adds to the body of literature regarding the potential for growth in people who have experienced a traumatic psychotic episode and also adds to the recovery literature within the psychosis field. These findings are hopeful for other service users in moving towards a recovery and

growth model of psychosis. The findings fit particularly well with Andresen et al's (2003) model of recovery. The present study also indicated a number of barriers to recovery, which is clinically useful in considering what types of barriers may be present and consideration needs to be given to minimising these barriers to change. One such area highlighted in the current research is the role the mental health system played in hindering progress. The loss of hope and coercion the system instilled was evident in participants' stories. Recent research and guidelines have highlighted the importance of hope and optimism in promoting recovery (NICE, 2009). This should be a priority for all mental health teams to aid positive change. There should be a greater focus on rehabilitation and in providing people with the space to explore their experiences and to identify what recovery means to them. Mental health services need promote the potential for recovery in people with psychosis and be aware of the barriers to this (particularly in relation to lost hope, coercion and stigma). Services should attempt to minimise barriers to engagement and recovery by removing many of the identified obstacles and focus on changing service delivery to achieve this.

The present findings also highlighted the need for routine assessment of early or significant traumatic experiences in people with psychosis, which is not outlined in recent documentation (NICE, 2009). The current literature, as highlighted in this paper, reflects the high comorbidity of PTSD in people with psychosis. This can usually result in more severe symptoms and greater treatment resistance (Schenkel, Spaulding, DeLillo & Silverstein, 2005); therefore a thorough understanding of previous traumas is important for planning future interventions and reducing the likelihood of the potential for re-traumatisation. Furthermore, the experience of hospitalisation can also be particularly traumatic. Mental health services should be aware of the potential for this in their clients and ensure regular face-to-face contact

whilst clients are in hospital to discuss issues of distress and consider routinely reassessing clients upon leaving hospital to assess for any traumatic reactions in relation to this.

The present study indicates that people with psychosis can achieve psychological growth and recovery. What is particularly interesting for clinical practice is that many mental health services continue to focus on symptom eradication/control/management. What proved most important in facilitating positive change in the present study was self-acceptance and awareness, finding meaning and purpose and regaining control over their lives. This consisted of participants incorporating their psychosis as a part of the self, rather than trying to eradicate it altogether. This fits well with the OVP model of growth proposed by Joseph and Linley (2005) and the model of recovery proposed by Andresen et al (2003). Therefore, psychological therapies which focus on aiding reconstructing the self and acceptance may be beneficial in supporting psychological growth and recovery. Whilst the recent NICE guidelines discuss a variety of psychological interventions for working with people with schizophrenia, the main focus is on offering all service users CBT (NICE, 2009). Furthermore, NICE (2009) reports that psychological interventions should aim “*to decrease the person’s vulnerability; reduce the impact of stressful events and situations; decrease distress and disability; minimise symptoms; improve the quality of life; reduce risk; improve communication and coping skills; and/or enhance treatment adherence*” (p. 195). Whilst CBT has demonstrated a good evidence base for working with people with psychosis (e.g. Frueh et al, 2009, Garety et al, 2008; Jackson et al, 2009), Borneo (2008) found that CBT was deemed to be less helpful than art therapies or talking therapies in a recent survey. The present study would support the use of more client-centred therapies (as highlighted by Joseph, 2004) in aiding focus on self-integration and self-acceptance, in increasing hope and self-esteem and in exploring their

personal experiences of psychosis to promote a greater understanding. However, it is also worth acknowledging the lack of empirical support for the use of these therapies for people with psychosis (NICE, 2009).

Theoretical Underpinnings and Epistemological Stance

Qualitative research is considered a human science whereby the interest of study is to understand the person and determine the underlying structures of their experience. It is through this mode of enquiry that “*general or universal meanings of experience are derived*” (Moustakas, 1994, p. 13). In contrast with the dominant, scientific quantitative approach, qualitative research involves the in-depth study of a person’s experience, rather than the reductionist perspective taken by the natural sciences. Qualitative research is data driven (hypothesis generation) rather than being theory led (hypothesis testing) and adopts an exploratory approach to a phenomenon being studied (Sciarra, 1999). Furthermore, qualitative research takes an idealist perspective, rather than the positivist perspective adopted by quantitative researchers. This difference in epistemology is important, particularly in relation to the ontology of reality. For example, quantitative research asserts the belief that there is only one reality that can be observed and this reality is knowable through the process of research (Cohen & Crabtree, 2008). Post-positivists assume that there is one reality, but this is measured imperfectly. This is different to qualitative perspectives, namely constructivist/interpretivist perspectives where they believe that multiple realities exist (Ponterotto, 2005). According to this perspective, reality is constructed based on our subjective understandings and is influenced within specific contexts. IPA sits within this understanding and some researchers have referred to IPA as ‘contextualist’ for this reason (Madill et al, 2000). Critical theories, such as social constructivism acknowledges that reality is shaped by

language, culture, gender, society and political values (Ponterotto, 2005). The concept of reality is important when assessing the validity of qualitative research (see extended background section for more information).

Ontology is also important when considering the concept of schizophrenia, which will be considered briefly here. The label schizophrenia has been applied by the medical model to reflect a true observable reality of illness. However, according to Laing (1967), rather than reflecting reality, schizophrenia reflects an ontological insecurity where the individual feels uncertain about his or her very way of being in the world. More recently, Ladrine (1992) described schizophrenia and psychotic symptoms as a cultural assumption in Western society about how the self should be experienced, placing this within the context of social constructionism. These differing epistemological perspectives on the concept of schizophrenia need to be considered in relation to the present study.

IPA was used in the present study. IPA adopts an idiographic approach to analysis by situating participants within their contexts and exploring their experiences at the individual level, rather than taking a nomothetic, group level approach as evident in quantitative methodology (Smith et al, 2009). Within IPA, the process of heuristic inquiry occurs whereby the researcher and participants are both the subject and object of investigation, as a "*relationship of intersubjectivity (occurs) involving the values, emotions, perceptions and cultural context of both parties*" (Sciarra, 1999, p. 39), rather than the researcher as external observer. The researchers, therefore, immerse themselves within the research by using both cognition and emotion to enter the participant's world. It is for this reason that the IPA researcher is learning within, rather than being the expert of their research.

IPA has two further theoretical axes, involving both phenomenology and interpretation (Smith et al, 2009). Phenomenology refers to “*knowledge as it appears to consciousness, the science of describing what one perceives, senses and knows in one’s immediate awareness and experience*” (Kockelmans, 1967). A phenomenological approach involves considering a person’s experience in order to obtain a rich description which, through reflection and interpretation, ultimately portrays the essence of the experience (Moustakas, 1994, p. 13). Being influenced by the philosopher Edmund Husserl (Moustakas, 1994; Smith et al, 2009, p. 12), phenomenology is embedded within the experiential field of qualitative psychology where the focus of enquiry is not on language per se, but also focuses on the internal, experiential experiences of the person. Husserl noted the importance of studying the ‘lifeworld’ (everyday life experiences), which provides “*the experiential grounding for...the objective or scientific world*” (Smith et al, 2009, p. 15), as science comes second to our personal experiences of it. Therefore, IPA takes a critical realist perspective (whilst also influenced by constructivism), in relation to Husserl’s belief that “*what appears in consciousness is an absolute reality*” (Moustakas, 1994, p. 27). Therefore, the epistemology of IPA assumes that there is no one true reality, only that which we subjectively experience within ourselves. It is not concerned with matters of fact but seeks to determine meanings. Within IPA, a person’s reality is derived from the story of people’s experiences and language to help us understand the essence of this. This is also the epistemological stance of the main researcher in the present study. IPA is also specifically interested in individuals as agents – being active in the external world and making sense of their experiences as they occur. Therefore, IPA is also influenced by the study of hermeneutics – the theory of interpretation – as highlighted by the philosopher Heidegger (Smith et al, 2009). People are considered to be active in making sense and interpreting their experiences. Within the study of IPA, the double hermeneutic approach is dominant,

whereby the researcher is trying to make sense of the participant making sense of their experiences. This interaction is crucial within IPA research as meanings and interpretation also occur as a result of social interactions (Smith, 1996).

Reflections

I engaged in the process of reflection during all stages of the study, from the early stages of conceptualising the design to completing the interviews and analysing the results. The following includes brief excerpts of the extracts taken from my reflective diary at the different stages of the research.

Conceptualising the research.

I initially considered studying people with a diagnosis of schizophrenia/psychosis. However, by using this terminology I am aligning myself with a positivist position, which was not a position I usually take in research. However, in working in a tradition which automatically, if not inadvertently, aligns itself with the medical model, this reflected the 'reality' with which I work in. I therefore had to consider my own presumptions and influences and had to reconsider my own philosophical position, taking the position of critical realist. Within this, I also had to consider how the wording of my research title would inadvertently influence people's perceptions of me and mine of them. I am presuming that their reality is the same as mine. That they view their difficulties as 'schizophrenia', rather than a number of symptoms which are at times distressing. I considered my own understanding of 'schizophrenia', or 'psychosis'. I held the belief that psychosis represents a number of symptoms that people experience. As such, they must represent their 'reality'. I therefore aimed to assess people presenting with these 'symptoms' as this was something which

they experienced, rather than something that was attributed to them by society. However, I am still implying the symptoms they have are a part of a medical 'illness' and falling into the trap of assuming that these experience are wrong and should not be experienced as highlighted by Ladrine (1992). Therefore, the terminology used prior to recruitment was difficult and something which I spent time considering. I still remain aware that through the wording of my research question, I am already influencing participants' stories and whilst trying to minimise this, it was a difficult process to overcome completely.

Meeting with JC was thought provoking and really helpful – had not considered that the support group I am recruiting from will hold its own epistemological position. I wonder how this differs with my own and if this will be evident in the interviews? How will this influence the direction of the interviews? Will my research end up reflecting the ideas of the support group rather than individuals? All things to be mindful of and will possibly need to consider in the discussion.

Prior to starting research.

In relation to the subject area, I was relatively naive; having previously worked on a part-time basis within an assertive outreach service as a researcher and never personally experienced mental health problems or trauma. In relation to personal development and growth, I experienced a significant bereavement at a young age and it was this that drove my career as a psychologist. I never discussed any of the above with participants as I did not want to influence the participants' own account of their experiences of growth. As a result, I had few preconceptions about what participants may bring to the interviews, other than a belief that people can experience growth in the face of adversity and a knowledge base on the impact that psychosis can have on a person's life. Furthermore, I held my own understanding on my reasons for positive and personal change (in relation to

supportive relationships, belief system and spirituality) and had these similar beliefs about what may have influenced the participants change and growth prior to interviews. As a result, I acknowledged these beliefs and attempted to bracket these preconceptions and focus on the experiences produced by participants. However, it is worth acknowledging that bracketing can only occur if beliefs are held in consciousness, so it was important to note these explicitly from the start and hope they don't influence the participants or the analysis.

During the study – interview stage.

I wonder whether my own expectations of what growth will look like in participants will be too much i.e. that I expect them to have had life altering experiences when maybe their growth will come from the small changes they have made. I feel I need to be open to their experiences and their own views of development as I am sure this will be different for everyone. I also expect people to be at different stages in the process of growth. I hope to remain cautious with my questioning so not to lead participants too much and to be led by the direction of participants (6th Nov 2008 – before 1st interview).

There was also a strong feeling at times of desperately wanting to change the mental health system, possibly reflecting the countertransference from participants. Whilst I was aware of some of the difficulties encountered within the system, the interviews gave me a real understanding of what it must be like for people entering the system and the subsequent coercive nature of services. As a trainee clinical psychologist, I also at times became disillusioned with the mental health system. I have no doubt that the interviews with the service users will change my own practice in the future, particularly in relation to listening to the stories of clients and focussing on the traumatic aspects of their symptoms in order to limit the potential for re-traumatisation.

Reflections on interviews.

His psychosis has meant that he has a feeling of loneliness and isolation – although he pointed to many aspects of his life which were more positive such as relationships with his family and trying to understand the meaning of life. Dominant themes seemed to be religion, family support, helplessness and depression and striving to help other...as this was the first interview, I felt pressured to 'find' growth and whilst I followed the interview script, I felt that I possibly influenced the direction of the interview too much. This shouldn't be the purpose of the interviews I need to consider allowing participants more freedom in discussing their stories and only asking the minimum of questions (19th Nov 2008 – after 1st interview)

I felt that she was testing me, making sure that she could trust me with her story. It was as though she was building up to telling me something important, making sure I would handle it sensitively. I felt it was important for me to hold back, to not ask too many questions and to allow her to share her story. When she did discuss it, I felt privileged to be hearing it. I was maybe overly cautious in my questioning around this area. Even now after the interview, I would still remain cautious. Whether this is me trying to protect the participant or protect myself from more in-depth discussions in this area I'm not sure. I predict it is possibly both, but also reflect that I am in the role of the researcher, not the clinician...The issue of diagnosis was prominent for her – there was a sense that this had somehow stripped her of her individuality. It tapped into my own dislike for diagnosis, although I tried to remain neutral so not to influence the direction of the interviews too much. I'll have to bear this in mind when listening to the interview again to ensure I did not feed into this. (9th Dec 2008)

He discussed the negatives around hospitals, psychiatrists, nurses but was relatively positive about psychologists. Was that

because I was interviewing him? Could this have affected the topic and direction of conversation? On one level, I wonder whether people were restrained from discussing psychology in a negative light, although at another level there was honest discussion in many other areas? It feels like something worth holding in mind as potentially impacting on the findings (31th July 2009)

I was overwhelmed at times with the magnitude of his experiences. I tried to consider what this must have been like for him but it was difficult. I'm beginning to really reflect on the impact that these interviews have had on me. It's made me consider my own position within the mental health system and has tapped into my own concerns and uneasiness regarding power and control. I felt angry for him, with the way he has been treated by others in the mental health system and society, possibly reflecting the countertransference in the room. It has really opened my eyes to the way that some aspects of the mental health system do not consider the individual needs of service users. The negative impact of the mental health system was dominant in his story. (19th June 2009)

Analysis.

Most participants reflected on the negatives of their experiences. Key themes included the mental health system (control? coercion? loss of hope?), symptoms, relationships. Most participants described how these were things that seemed to 'get in the way'. Of change? Possibly reflecting people's negative experiences (descriptive)? Adam reflects about barriers – at an interpretative level the negatives were barriers/hindrances to moving forward – lots of metaphors reflecting being stopped or reflecting movement – possibly barriers and facilitators of change?

Would have been helpful to follow-up on this. Describes regaining control over her life but she doesn't expand on how she has

done this and what changes have been made as a result of this. May have implicated greater findings.

It's interesting how many participants reflected on the negative side of the mental health system – very few positives. It seems this in itself is a barrier to change.

Total word count for thesis (excluding contents, acknowledgements, references and appendices) – 31,235

References

- Achté, K., Jarho, L., Kyykkä, T., & Vesterinen, E. (1991). Paranoid disorders following war brain damage. Preliminary report. *Psychopathology, 24*(5), 309-315.
- Affleck, G., & Tennen, H. (1996). Construing benefits from adversity: Adaptational significance and dispositional underpinnings. *Journal of Personality, 64*, 899–922.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders*. (4th ed.). Washington, DC: Author.
- American Psychiatric Association (APA). (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. TR). Washington, DC: Author.
- Andresen, R., Oades, L., & Caputi, P. (2003). The experience of recovery from schizophrenia: Towards an empirically validated stage model. *Australian and New Zealand Journal of Psychotherapy, 37*(5), 586–594.
- Angermeyer, M. C., & Schulze, B. (2001). Reinforcing stereotypes: How the focus on forensic cases in news reporting may influence public attitudes towards the mentally ill. *International Journal of Law and Psychiatry, 24*, 469–486.
- Antoni, M. H., Lehman, J. M., Kilbourn, K. M., Boyers, A. E., Culver, J. L., Alferi, S. M., ...Carver, C. S. (2001). Cognitive-behavioral stress management intervention decreases the prevalence of depression and enhances benefit finding among women under treatment for early stage breast cancer. *Journal of Health Psychology, 20*, 20-32.

- Arciniegas, D. B., Harris, S. N., & Brousseau, K. M. (2003). Psychosis following traumatic brain injury. *International Review of Psychiatry, 15*(4), 328-340.
- Bak, M., Krabbendam, L., Janssen, I., de Graaf, R., Vollebergh, W., & van Os, J. (2005). Early trauma may increase the risk for psychotic experiences by impacting on emotional response and perception of control. *Acta Psychiatrica Scandinavica, 112*, 360–366.
- Bellack, A. S. (2006). Scientific and consumer models of recovery in schizophrenia: Concordance, contrasts, and implications. *Schizophrenia Bulletin, 32*, 432–442.
- Bellizzi, K. M., & Blank, T. O. (2006). Predicting posttraumatic growth in breast cancer survivors. *Health Psychology, 25*(1), 47–56.
- Birchwood, M. (2003). Pathways to emotional dysfunction in first-episode psychosis. *British Journal of Psychiatry, 182*, 373–375.
- Birchwood, M., Gilbert, P., Gilbert, J., Trower, P., Meaden, A., Hay, J., Murray, E., & Miles, J. N. V. (2004). Interpersonal and role-related schema influence the relationship with the dominant 'voice' in schizophrenia: a comparison of three models. *Psychological Medicine, 34*, 1571–1580.
- Birchwood, M., & Spencer, E. (2001). Early intervention in psychotic relapse. *Clinical Psychology Review, 21*(8), 1211–1226.
- Bobes, J., Ciudad, A., Álvarez, E., San, L., Polavieja, P., & Gilaberte, I. (2009). Recovery from schizophrenia: Results from a 1-year follow-up observational study of patients in symptomatic remission. *Schizophrenia Research, 115*, 58–66.

- Boevink, W. A. (2006). From being a disorder to dealing with life: An experiential exploration of the association between trauma and psychosis. *Schizophrenia Bulletin*, 32(1), 17–19.
- Bogár, K., & Perczel, D. F. (2007). Trauma and psychosis. *Psychiatry Hungary*, 22(4), 300-310.
- Bonney, S., & Stickley, T (2008). Recovery and mental health: a review of the British Literature. *Journal of Psychiatric and Mental Health Nursing*, 15, 140–153.
- Borneo, A. (2008). *Your choice: results from the Your Treatment, Your Choice survey 2008--final report*. Available at: www.rethink.org/document.rm?id=6858 (accessed September 2009)
- Bramley, N., & Eatough, V. (2005). The experience of living with Parkinson's disease: An interpretative phenomenological analysis case study. *Psychology and Health*, 20(2), 223–235.
- British Psychological Society. (2000). *Recent advances in understanding mental illness and psychotic experiences*. Leicester: British Psychological Society.
- Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health*, 21, 87–108.
- Butler, R. W., Mueser, K. T., Sprock, J., & Braff, D. L. (1996). Positive symptoms of psychosis in posttraumatic stress disorder. *Biological Psychiatry*, 39, 839—844.
- Calhoun, L. G., Cann, A., Tedeschi, R. G., & McMillan, J. (2000). A correlational test of the relationship between posttraumatic growth, religion, and cognitive processing. *Journal of Traumatic Stress*, 13, 521–527.

- Calhoun, L. G., & Tedeschi, R. G. (2004). The foundations of posttraumatic growth: New considerations. *Psychological Inquiry, 15*(1), 93-102.
- Calhoun, L. G., & Tedeschi, R. G. (2008). Beyond the concept of recovery: Growth and the experience of loss. *Death Studies, 32*, 27–39.
- Calhoun, P. S., Stechuchak, K. M., Strauss, J., Bosworth, H. B., Marx, C. E., & Butterfield, M. I. (2007). Interpersonal trauma, war zone exposure, and posttraumatic stress disorder among veterans with schizophrenia. *Schizophrenia Research, 91*, 210–216.
- Campbell, M. L. C., & Morrison, A. P. (2007). The relationship between bullying, psychotic-like experiences and appraisals in 14–16-year olds. *Behaviour Research and Therapy, 45*, 1579–1591.
- Charmaz, K. (1995). The body, identity, and self: adapting to impairment. *Sociological Quarterly, 36*, 657-680.
- Cheng, C., Wong, W., & Tsang, K. W. (2006). Perceptions of benefits and costs during SARS outbreak: An 18-month prospective study. *Journal of Consulting and Clinical Psychology, 74*, 870–879.
- Chisholm, B., Freeman, D., & Cooke, A. (2006). Identifying potential predictors of traumatic reactions to psychotic episodes. *British Journal of Clinical Psychology, 45*, 545–559.
- Clapp, J. D., & Beck, G. (2009). Understanding the relationship between PTSD and social support: The role of negative network orientation. *Behaviour Research and Therapy, 47*, 237–244.
- Cloitre, M., Koenen, K. C., Cohen, L. R., & Han, H. (2002). Skills training in affective and interpersonal regulation followed by exposure: A phase-based treatment for PTSD related to

childhood abuse. *Journal of Consulting and Clinical Psychology*, 70(5), 1067-1074.

Chun, S., & Lee, Y. (2008). The experience of posttraumatic growth for people with spinal cord injury. *Qualitative Health Research*, 18, 877-890.

Cobb, A. R., Tedeschi, R. G., Calhoun, L. G., & Cann, A. (2006). Correlates of posttraumatic growth in survivors of intimate partner violence. *Journal of Traumatic Stress*, 19(6), 895–903.

Cohen, D. J., & Crabtree, B. F. (2008). Evaluative criteria for qualitative research in health care: Controversies and recommendations. *The Annals of Family Medicine*, 6, 331-339. DOI: 10.1370/afm.818

Collins, R. L., Taylor, S. E., & Skokan, L. A. (1990). A better world or a shattered vision? Changes in perspectives following victimization. *Social Cognition*, 8, 263–285.

Collicutt McGrath, J., & Linley, P. A. (2006). Posttraumatic growth in acquired brain injury: A preliminary small scale study. *Brain Injury*, 20, 767-773.

Cordova, M. J., Cunningham, L. L. C., Carlson, C. R., & Andrykowski, M. A. (2001). Posttraumatic growth following breast cancer: A controlled comparison study. *Health Psychology*, 20, 176–185.

Cupitt, C., Wolfson, P., Okon, E., Materson, D., & Popelyuk, D. (2009). Developing recovery-orientated practice. *Clinical Psychology Forum*, 203, 24-28.

Cusack, K. J., Frueh, B. C., Hiers, T., Suffoletta-Maierle, S., & Bennett, S. (2003). Trauma within the psychiatric setting: A preliminary empirical report. *Administration and Policy in Mental Health*, 30(5), 453-460.

- Dancu, C. V., Riggs, D. S., Hearst-Ikeda, D., Shoyer, B. G., & Foa, E. B. (1996). Dissociative experiences and posttraumatic stress disorder among female victims of criminal assault and rape. *Journal of Traumatic Stress, 9*(2), 253-267.
- Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: one strategy for lessening confusion plaguing recovery. *Journal of Mental Health, 16*(4), 459-470.
- Davidson, L., Schmutte, T., Dinzeo, T., & Andres-Hyman, R. (2008). Remission and recovery in schizophrenia: Practitioner and patient perspectives. *Schizophrenia Bulletin, 34*(1), 5–8.
- Dean, K., Moran, P., Fahy, T., Tyrer, P., Leese, M., Creed, F. et al. (2007). Predictors of violent victimization amongst those with psychosis. *Acta Psychiatrica Scandinavica, 116*, 345–353.
- Deering, C. G., Glover, S. G., Ready, D., Eddleman, H. C., & Alarcon, R. D. (1996). Unique patterns of comorbidity in posttraumatic stress disorder from different sources of trauma. *Comprehensive Psychiatry, 37*(5), 336-346.
- Department of Health (2001). *The journey to recovery: The government's vision for mental health care*. London: Authors.
- Dunkley, J. E., Bates, G. W., Foulds, M., & Fitzgerald, P. (2007). Understanding adaptation to first-episode psychosis: The relevance of trauma and posttraumatic growth. *The Australasian Journal of Disaster and Trauma Studies, 1*.
- Eisenberg, L. (2006). Violence and the mentally ill: Victims, not perpetrators. *Archives of General Psychiatry, 62*, 825–826.
- Ellason, J. W., & Ross, C. A. (1997). Childhood trauma and psychiatric symptoms, *Psychological Reports, 80*(2), 447-450.

- Elliott, R., Fischer, C., & Rennie, D. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*, 215 – 229.
- Engelkemeyer, S. M., & Marwit, S. J. (2008). Posttraumatic growth in bereaved parents. *Journal of Traumatic Stress, 21*(3), pp. 344–346
- Fleming, M., & Richards, D. (2006). The relationship between traumatic reactions and psychosis. *Mental Health Practice, 9*(9), 18-22.
- Frazier, P., Conlon, A., & Glaser, T. (2001). Positive and negative life changes following sexual assault. *Journal of Consulting and Clinical Psychology, 69*(6), 1048-1055.
- Frueh, B. C., Grubaugh, A. L., Cusack, K. J., Kimble, M. O., Elhai, J. D., & Knapp, R. G. (2009). Exposure-based cognitive-behavioral treatment of PTSD in adults with schizophrenia or schizoaffective disorder: A pilot study. *Journal of Anxiety Disorders, 23*(5), 665-675.
- Frueh, B. C., Knapp, R. G., Cusack, K. J., Grubaugh, A. L., Sauvageot, J. A., Cousins, V. C., ...Hiers, T. G. (2005). Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric Services, 56*(9), 1123-1133.
- Garety, P. A., Fowler, D. G., Freeman, D., Bebbington, P., Dunn, G., & Kuipers, E. (2008). Cognitive behavioural therapy and family intervention for relapse prevention and symptoms reduction in psychosis: Randomised controlled trial. *British Journal of Psychiatry, 192*, 412-423.
- Goodman, L. A., Rosenberg, S. D., Mueser, K. T., & Drake, R. E. (1997). Physical and sexual assault history in women with

serious mental illness: Prevalence, correlates, treatment, and future research directions. *Schizophrenia Bulletin*, 23, 685–696.

Harrison, G., Hopper, K., Craig, T., Laska, E., Siegel, C., Wanderling, J. et al. (2001). Recovery from psychotic illness: a 15 and 25 year international follow up study. *British Journal of Psychiatry*, 178, 506–517.

Heins, T., Gray, A., & Tennant, M. (1990). Persisting hallucinations following childhood sexual abuse. *Australian and New Zealand Journal of Psychiatry*, 24, 561–565.

Higginson, S., & Mansell, W. (2008). What is the mechanism of psychological change? A qualitative analysis of six individuals who experienced personal change and recovery. *Psychology and Psychotherapy: Theory, Research and Practice*, 81, 309–328.

Holeva, V., Tarrier, N., & Wells, A. (2001). Prevalence and predictors of acute stress disorder and PTSD following road traffic accidents: Thought control strategies and social support. *Behavior Therapy*, 32(1), 65-83.

Holmes, E. A., & Steel, C. (2004). Schizotypy: a vulnerability factor for traumatic intrusions. *Journal of Nervous and Mental Disease*, 192(1), 28-34.

Houston, J. E., Murphy, J., Adamson, G., Stringer, M., & Shevlin, M. (2008). Childhood sexual abuse, early cannabis use, and psychosis: testing an interaction model based on the National Comorbidity Survey. *Schizophrenia Bulletin*, 34(3), 580-5.

Iversen, A. C., Fear, N. T., Ehlers, A., Hacker Hughes, J., Hull, L., Earnshaw, M. et al. (2008). Risk factors for post-traumatic stress disorder among UK Armed Forces personnel. *Psychological Medicine*, 38, 511–522.

- Ivezic, S., Oruc, L., & Bell, P. (1999). Psychotic symptoms in post-traumatic stress disorder. *Military Medicine*, 164(1), 73-75.
- Jackson, C., Knott, C., Skeate, A., & Birchwood, M. (2004). The trauma of first episode psychosis: the role of cognitive mediation. *Australian and New Zealand Journal of Psychiatry*, 38, 327-333.
- Jackson, C., Trower, P., Reid, I., Smith, J., Hall, M., Townend, M., Barton, K., et al (2009). Improving psychological adjustment following a first episode of psychosis: A randomised controlled trial of cognitive therapy to reduce post psychotic trauma symptoms. *Behaviour Research and Therapy*, 47, 454–462.
- Janoff-Bulman, R. (1992). *Shattered assumptions*. New York: Free Press.
- Janssen, I., Krabbendam, L., Bak, M., Hanssen, M., Vollebergh, W., de Graaf, R. et al. (2004). Childhood abuse as a risk factor for psychotic experiences. *Acta Psychiatrica Scandinavica*, 109, 38–45.
- Janssen, I., Krabbendam, L., Hanssen, M., Bak, M., Vollebergh, W., de Graaf, R. et al. (2005). Are apparent associations between parental representations and psychosis risk mediated by early trauma? *Acta Psychiatrica Scandinavica*, 112, 372–375.
- Jeffries, J. J. (1977). The trauma of being psychotic: a neglected element in the management of chronic schizophrenia? *Canadian Psychiatric Association Journal*, 22(5), 199-206.
- Jensen, L. W., & Wadkins, T. A. (2007). Mental health success stories: finding paths to recovery. *Issues in Mental Health Nursing*, 28, 325-340.
- Joseph, S. (2004). Client-centred therapy, post-traumatic stress disorder and post-traumatic growth: Theoretical perspectives and

practical implications. *Psychology and Psychotherapy: Theory, Research and Practice*, 77, 101–119.

Joseph, S. & Linley, P. A. (2005). Positive adjustment to threatening events: An organismic valuing theory of growth through adversity. *Review of General Psychology*, 9, 262–280.

Joseph, S., & Linley, P. A. (2006). Growth following adversity: Theoretical perspectives and implications for clinical practice. *Clinical Psychology Review*, 26, 1041–1053.

Joseph, S., Linley, P. A., & Harris, G. J. (2005). Understanding positive change following trauma and adversity: Structural clarification. *Journal of Loss and Trauma*, 10, 83-96.

Joseph, S., Linley, P. A., Shevlin, M., Goodfellow, B., & Butler, L. (2006). Assessing positive and negative changes following adversity: A short form of the Changes in Outlook Questionnaire. *Journal of Loss and Trauma*, 11, 85-99.

Kelly, M., & Gamble, C. (2005). Exploring the concept of recovery in schizophrenia. *Journal of Psychiatric and Mental Health Nursing*, 12, 245-251.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry*, 52, 1048-1060.

Kilcommons, A. M., & Morrison, A. P. (2005). Relationships between trauma and psychosis: an exploration of cognitive and dissociative factors. *Acta Psychiatrica Scandinavica*, 112, 351–359.

Kilcommons, A. M., Morrison, A. P., Knight, A., & Lobban, F. (2008). Psychotic experiences in people who have been sexually

assaulted. *Social Psychiatry and Psychiatric Epidemiology*, 43(8), 602-611.

Knight, M. T. D., Wykes, T., & Hayward, P. (2003). 'People don't understand': An investigation of stigma in schizophrenia using interpretative phenomenological analysis (IPA). *Journal of Mental Health*, 12(3), 209-222. doi: 10.1080/0963823031000118203

Knudson, B., & Coyle, A. (2002). The experience of hearing voices: An interpretative phenomenological analysis. *Existential Analysis*, 13(1), 117-134.

Kockelmans, J. J. (1967). *Phenomenology* (Ed.). Garden City, New York: Doubleday. Taken from: C. Moustakas. *Phenomenological Research Methods*. Sage Publications, London.

Koren, D., Norman, D., Cohen, A., Berman, J., & Klein, E. M. (2005). Increased PTSD risk with combat-related injury: A matched comparison study of injured and uninjured soldiers experiencing the same combat events. *American Journal of Psychiatry*, 162, 276–282.

Kuipers, E., Garety, P., Fowler, D., Freeman, D., Dunn, G., & Bebbington, P. (2006). Cognitive, emotional, and social processes in psychosis: refining cognitive behavioral therapy for persistent positive symptoms. *Schizophrenia Bulletin*, 32(S1), S24–S31.

Kupper, Z., & Hoffman, R. (2000). Course patterns of psychosocial functioning in schizophrenia patients attending a vocational rehabilitation program. *Schizophrenia Bulletin*, 26, 681–698.

Laing, R. D. (1967). *The politics of experience*. New York: Random House.

- Landrine, H. (1992). Clinical implications of cultural differences: The referential versus the indexical self. *Clinical Psychology Review, 12*, 401-415.
- Larkin, W., & Morrison, A. P. (2006). *Trauma and psychosis: New directions for theory and therapy*. East Sussex, UK: Routledge.
- Lev-Wiesel, R., Amir, M., & Besser, A. (2005). Posttraumatic growth among female survivors of childhood sexual abuse in relation to perpetrator identity. *Journal of Loss and Trauma, 10*, 7-17.
- Lieberman, R. P., & Kopelowicz, A. (2005). Recovery From Schizophrenia: A Concept in Search of Research. *Psychiatric Services, 56*(6), 735-742.
- Lieberman, R. P., Kopelowicz, A., Ventura, J., & Gutkind, D. (2002). Operational criteria and factors related to recovery from schizophrenia. *International Review of Psychiatry, 14*, 256-272.
- Link, B. G., Cullen, F. T., Struening, E., Shrout, P. E., & Dohrenwend, B. P. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review, 54*(3), 400-423.
- Link, N., Victor, B., & Binder, R. L. (1985). Psychosis in children of Holocaust survivors: influence of the Holocaust in the choice of themes in their psychoses. *Journal of Nervous and Mental Disease, 173*(2), 115-117.
- Linley, P. A., & Joseph, S. (2003). Trauma and personal growth. *The Psychologist, 16*(3), 135.
- Linley, P. A., & Joseph, S. (2004). Positive change following trauma and adversity: a review. *Journal of Traumatic Stress, 17*(1), 11-21.

- Linley, P. A., & Joseph, S. (2005). The human capacity for growth through adversity. *American Psychologist*, *60*(3), 262-264. DOI: 10.1037/0003-066X.60.3.262b
- Linley, P. A., & Joseph, S. (2006). The positive and negative effects of disaster work: A preliminary investigation. *Journal of Loss and Trauma*, *11*, 229–245.
- Lundy, M. S. (1992). Psychosis-induced posttraumatic stress disorder. *American Journal of Psychotherapy*, *46*(3), 485-491.
- Lysaker, P. H., & LaRocco, V. A. (2008). The prevalence and correlates of trauma-related symptoms in schizophrenia spectrum disorder. *Comprehensive Psychiatry*, *49*, 330–334.
- Lysaker, P. H. & Lysaker, J. T. (2001). Psychosis and the disintegration of dialogical self-structure: Problems posed by schizophrenia for the maintenance of dialogue. *British Journal of Medical Psychology*, *74*, 23–33.
- Mackrell, L., & Lavender, T. (2004). Peer relationships in adolescents experiencing a first episode of psychosis. *Journal of Mental Health*, *13*(5), 467-479.
- Madill, A., Jordon, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, *91*, 1-20.
- Maercker, A., & Zoellner, T. (2004). The Janus face of self-perceived growth: Toward a two-component model of posttraumatic growth. *Psychological Inquiry*, *15*, 41–48.
- Maguen, S., Vogt, D. S., King, L. A., King, D. W., & Litz, B. T. (2006). Posttraumatic growth among Gulf War I veterans: The predictive

role of deployment-related experiences and background characteristics. *Journal of Loss and Trauma*, 11, 373–388.

Mason, O. J., Brett, E., Collinge, M., Curr, H., & Rhodes, J. (2009). Childhood abuse and the content of delusions. *Child Abuse & Neglect*, 33, 205–208.

McAllister, T. W., & Ferrell, R. B. (2002). Evaluation and treatment of psychosis after traumatic brain injury. *Neurorehabilitation*, 17(4), 357-68.

McCann, T. (2002). Uncovering hope with clients who have psychotic illness, *Journal of Holistic Nursing*, 20(1), 81-89.

McCann, T. V. & Clark, E. (2004). Advancing self-determination with young adults who have schizophrenia, *Journal of Psychiatric and Mental Health Nursing*, 11, 12-20.

McFarland, C., & Alvaro, C. (2000). The impact of motivation on temporal comparisons: Coping with traumatic events by perceiving personal growth. *Journal of Personality and Social Psychology*, 79, 327-343. DOI: 10.1037/0022-3514.79.3.327

McFarlane, A. C., Bookless, C., & Air, T. (2001). Posttraumatic stress disorder in a general psychiatric inpatient population. *Journal of Traumatic Stress*, 14(4), 633-645.

McFarlane, A. C., & Papay, P. (1992). Multiple diagnoses in posttraumatic stress disorder in the victims of a natural disaster. *Journal of Nervous and Mental Disease*, 180(8), 498-504.

McGorry, P. D., Chanen, A., McCarthy, E., VanRiel, R., McKenzie, D., & Singh, B. S. (1991). Posttraumatic stress disorder following recent-onset psychosis: An unrecognized post-psychotic syndrome. *Journal of Nervous and Mental Disease*, 179, 253-258.

- Mitchell, A., Clegg, J., & Furniss, F. (2006). Exploring the meaning of trauma with adults with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities, 19*, 131–142.
- Morgan, C., & Fisher, H. (2007). Environmental factors in schizophrenia: Childhood trauma – a critical review. *Schizophrenia Bulletin, 33*(1), 3-10.
- Morrison, A. P., Beck, A. T., Glentworth, D., Dunn, H., Reid, G. S., Larkin, W. et al. (2002). Imagery and psychotic symptoms: a preliminary investigation. *Behaviour Research and Therapy, 40*, 1053–1062.
- Morrison, A., Bowe, S., Larkin, W., & Nothard, S. (1999). The psychological impact of psychiatric admission: Some preliminary findings. *The Journal of Nervous and Mental Disease, 187*(4), 250-253.
- Morrison, A. P., Frame, L., & Larkin, W. (2003). Relationships between trauma and psychosis: A review and integration. *British Journal of Clinical Psychology, 42*, 331–353.
- Mosher, C. E., Danoff-Burg, S., & Brunker, B. (2006). Post-traumatic growth and psychosocial adjustment of daughters of breast cancer survivors. *Oncology Nursing Forum, 33*(3), 543-551.
- Moustakas, C. (1994). *Phenomenological Research Methods*. Sage Publications, London
- Mueser, K. T., Goodman, L. B., Trumbetta, S. L., Rosenberg, S. D., Osher, C., Vidaver, R. et al. (1998). Trauma and posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology, 66*(3), 493–499.

- Mueser, K. T., & Rosenberg, S. D. (2003). Treating the trauma of first episode psychosis: A PTSD perspective. *Journal of Mental Health, 12*(2), 103–108.
- Mueser, K. T., Rosenberg, S. D., Goodman, L. A., & Trumbetta, S. L. (2002). Trauma, PTSD and the course of severe mental illness; an interactive model. *Schizophrenia Research, 53*, 123-143.
- Mueser, K. T., Rosenberg, S. D., Xie, H., Jankowski, M. K., Bolton, E. E., Lu, W. et al. (2008). A randomised controlled trial of cognitive-behavioural treatment for posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology, 76*(2), 259-271.
- Mueser, K. T., Salyers, M. P., Rosenberg, S. D., Ford, J. D., Fox, L., & Carty, P. (2001). Psychometric evaluation of trauma and posttraumatic stress disorder assessments in persons with severe mental illness. *Psychological Assessment, 13*(1), 110-117.
- Mueser, K. T., Salyers, M. P., Rosenberg, S. D., Goodman, L. A., Essock, S. M., Osher, F. C. et al. (2004). Interpersonal trauma and posttraumatic stress disorder in patient with severe mental illness: Demographic, clinical and health correlates. *Schizophrenia Bulletin, 30*(1), 45-57.
- National Institute for Health and Clinical Excellence (2009). *Schizophrenia: Core interventions in the treatment and management of schizophrenia in primary and secondary care (update)*. London: Authors.
- National Institute for Mental Health in England (2005). *Guiding statement on recovery*. London, Authors.

- Neria, Y., Bromet, E. J., Sievers, S., Lavelle, J., & Fochtmann, L. J. (2002). Trauma exposure and posttraumatic stress disorder in psychosis: Findings from a first-admission cohort. *Journal of Consulting and Clinical Psychology, 70*(1), 246–251.
- Neria, Y., Nandi, A., & Galea, S. (2008). Post-traumatic stress disorder following disasters: A systematic review. *Psychological Medicine, 38*, 467–480.
- Newton, E., Larkin, M., Melhuish, R., & Wykes, T. (2007). More than just a place to talk: Young people's experiences of group psychological therapy as an early intervention for auditory hallucinations. *Psychology and Psychotherapy: Theory, Research and Practice, 76*, 267–283.
- Norman, R. M. G., Malla, A. K., Manchanda, R., Harricharan, R., Takhar, J., & Northcott, S. (2005). Social support and three-year symptom and admission outcomes for first episode psychosis. *Schizophrenia Research, 80*, 227–234.
- O'Leary, V. E., & Ickovics, J. R. (1995). Resilience and thriving in response to challenge: An opportunity for a paradigm shift in women's health. *Women's Health: Research on Gender, Behavior, and Policy, 1*, 121–142.
- Ozer, E. J., Best, S. R., Lipsey, T. L., & Weiss, D. S. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis. *Psychological Bulletin, 129*, 52–73.
- Pals, J. L., & McAdams, D. P. (2004). The transformed self: Narrative understanding of posttraumatic growth. *Psychological Inquiry, 15*(10), 65-69.

- Park, C. L., & Ai, A. L. (2006). Meaning making and growth: new directions for research on survivors of trauma. *Journal of Loss and Trauma, 11*, 389–407.
- Park, C. L. & Folkman, S. (1997). Meaning in the context of stress and coping. *General Review of Psychology, 1*, 115–144.
- Park, C. L., & Helgeson, V. S. (2006). Introduction to the special section: Growth following highly stressful life events—current status and future directions. *Journal of Consulting and Clinical Psychology, 74*(5), 791–796.
- Payne, A. J., Joseph, S., & Tudway, J. (2007). Assimilation and accommodation processes following traumatic experiences. *Journal of Loss and Trauma, 12*, 73–89.
- Perkins, R. (2003). *The altar of independence*. Open Mind, 119, 6.
- Perry, B. M., Taylor, D., & Shaw, S. K. (2007). "You've got to have a positive state of mind": an interpretative phenomenological analysis of hope and first episode psychosis. *Journal of Mental Health, 16*(6), 781-793.
- Pitt, L., Kilbride, M., Nothard, S., Welford, M., & Morrison, A.P. (2007). Researching recovery from psychosis: A user led project. *Psychiatric Bulletin, 31*, 55-60
- Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology, 52*(2), 126-136.
- Priebe, S., Bröker, M., & Gunkel, S. (1998). Involuntary admission and posttraumatic stress disorder symptoms in schizophrenia patients. *Comprehensive Psychiatry, 39*(4), 220-224

- Read, J. (1997). Child abuse and psychosis: a literature review and implications for professional practice. *Professional Psychology: Research and Practice*, 28, 448–456.
- Read, J., & Ross, C. A. (2003). Psychological trauma and psychosis: Another reason why people diagnosed schizophrenic must be offered psychological therapies. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, 31(1), 247–268.
- Read, J., Van Os, J., Morrison, A. P., & Ross, C. A. (2005). Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica*, 112, 330-350.
- Repper, J. M., & Perkins, R. E. (2003). *Social inclusion and recovery: a model for mental health practice*. London: Bailliere Tindall.
- Resnick, S. G., Bond, G. R., & Mueser, K. T. (2003). Trauma and posttraumatic stress disorder in people with schizophrenia. *Journal of Abnormal Psychology*, 112(3), 415–423.
- Rheingold, A. A., Smith, D. W., Ruggiero, K. J., Saunders, B. E., Kilpatrick, D. G., & Resnick, H. S. (2004). Loss, trauma exposure and mental health in a representative sample of 12-17 year-old youths: Data from the national survey of adolescents. *Journal of Loss and Trauma*, 9(1), 1-19.
- Roe, D. (2001). Progressing from patienthood to personhood across the multidimensional outcomes in schizophrenia and related disorders. *Journal of Nervous and Mental Disease*, 189, 691–699.

- Roe, D., Yanos, P. T., & Lysaker, P. H. (2006). Coping with psychosis: An integrative developmental framework. *Journal of Nervous and Mental Disease, 194*(12), 917–924.
- Rosenberg, S. D., Mueser, K. T., Jankowski, M. K., Salyers, M. P., & Acker, K. (2004). Cognitive–Behavioral Treatment of PTSD in severe mental illness: results of a pilot study. *American Journal of Psychiatric Rehabilitation, 7*, 171–186.
- Rosenberg, S. D., Lu, W., Mueser, K. T., Jankowski, M. K., & Cournos, F. (2007). Correlates of adverse childhood events among adults with schizophrenia spectrum disorders. *Psychiatric Services, 58*, 245–253.
- Salick, E. C., & Auerbach, C. F. (2006). From devastation to integration: Adjusting to and growing from medical trauma. *Qualitative Health Research, 16*, 1021-1037.
- Sass, L. A. (2007). ‘Schizophrenic person’ or ‘person with schizophrenia?’: an essay on illness and the self. *Theory Psychology, 17* (3), 395-420
- Sautter, F. J., Brailey, K., Uddo, M. M., Hamilton, M. F., Beard, M. G., & Borges, A. H. (1999). PTSD and comorbid psychotic disorder: Comparison with veterans diagnosed with PTSD or psychotic disorder. *Journal of Traumatic Stress, 12*(1), 73-88.
- Schenkel, L. S., Spaulding, W. D., DiLillo, D., & Silverstein, S. M. (2005). Histories of childhood maltreatment in schizophrenia: Relationships with premorbid functioning, symptomatology, and cognitive deficits. *Schizophrenia Research, 76*, 273–286.
- Schiffman, J., LaBrie, J., Carter, J., Tyrone, C., Schulsinger, F., Parnas, J., et al. (2002). Perception of parent-child relationships in high-

risk families, and adult schizophrenia outcome of offspring. *Journal of Psychiatric Research*, 36, 41–47

Sciarra, D. (1999). The Role of the Qualitative Researcher. Taken from: M. Kapala & L. A. Suzuki (eds). *Using Qualitative Methods in Psychology*. Sage Publications Ltd. London: UK.

Shakespeare-Finch, J., & Copping, A. (2006). A grounded theory approach to understanding cultural differences in posttraumatic growth. *Journal of Loss and Trauma*, 11, 355-371.

Shalev, A. Y. (1992). Posttraumatic stress disorder among injured survivors of a terrorist attack: predictive value of early intrusion and avoidance symptoms. *Journal of Nervous and Mental Disease*, 180, 505–509.

Shaw, K., McFarlane, A., & Bookless, C. (1997). The phenomenology of traumatic reactions to psychotic illness. *Journal of Nervous and Mental Disease*, 185(7), 434-441.

Shaw, K., McFarlane, A. C., Bookless, C., & Air, T. (2002). The aetiology of postpsychotic posttraumatic stress disorder following a psychotic episode. *Journal of Traumatic Stress*, 15(1), 39–47.

Shevlin, M., Houston, J. E., Dorahy, M. J., & Adamson, G. (2008). Cumulative traumas and psychosis: an analysis of the national comorbidity survey and the British Psychiatric Morbidity Survey. *Schizophrenia Bulletin*, 34(1), 193-199.

Silverstein, S. M., & Bellack, A. S. (2008). A scientific agenda for the concept of recovery as it applies to schizophrenia. *Clinical Psychology Review*, 28, 1108-1124.
doi:10.1016/j.cpr.2008.03.004

Silverstein, S. M., Wong, M. H., Wilkniss, S. M., Bloch, A., Smith, T. E., Savitz, A., et al. (2006). Behavioral rehabilitation of the

“treatment-refractory” schizophrenia patient: Conceptual foundations, interventions, interpersonal techniques, and outcome data. *Psychological Services*, 3, 145–169.

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health*, 11, 261–271.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage Publications Ltd.

Smith, J. A., & Osborn, M. (2003). Interpretative Phenomenological Analysis. In J. A. Smith (Ed.) *Qualitative Psychology: A Practical Guide to Research Methods*. London: Sage Publications Ltd.

Smith, S. G., & Cook, S. L. (2004). Are reports of posttraumatic growth positively biased? *Journal of Traumatic Stress*, 17(4), 353-358.

Spinelli, E. (1989). *The interpreted world: An introduction to phenomenological psychology*. London: Sage publications Ltd.

Taku, K., Calhoun, L. G., Tedeschi, R. G., Gil-Rivas, V., Kilmer, R. P., & Cann, A. (2007). Examining posttraumatic growth among Japanese university students. *Anxiety, Stress and Coping*, 20(4), 353-367.

Tarrier, N. (2005) Co-morbidity and associated clinical problem in schizophrenia: their nature and implications for comprehensive cognitive-behavioural treatment. *Behaviour Change*, 22, 125–142.

Tarrier, N., Khan, S., Cater, J., & Picken, A. (2007). The subjective consequences of suffering a first episode psychosis: trauma and suicide behaviour. *Social Psychiatry and Psychiatric Epidemiology*, 42, 29–35.

- Tedeschi, R. G., & Calhoun, C. G. (1995). *Trauma and transformation: Growing in the aftermath of suffering*. Thousand Oaks, CA: Sage.
- Tedeschi, R. G., & Calhoun, L. G. (1996). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9*, 455–471.
- Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: A new perspective on psychotraumatology, *Psychiatric Times, 21*(4), 58-60.
- Tedeschi, R. G., & Calhoun, L. G. (2008). Beyond the concept of recovery: growth and the experience of loss. *Death studies, 32*(1), 27-39.
- Terhakopian, A., Sinaii, N., Engel, C. C., Schnurr, P. P., & Hoge, C. W. (2008). Estimating population prevalence of Posttraumatic Stress Disorder: An example using the PTSD checklist. *Journal of Traumatic Stress, 21*(3), 290–300.
- Thornicroft, G., Brohan, E., Rose, D., Sartorius, N., & Leese, M. (2009). Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey. *Lancet, 373*, 408-415.
- Uçok, A., & Bikmaz, S. (2007). The effects of childhood trauma in patients with first-episode schizophrenia. *Acta Psychiatrica Scandinavica, 116*(5), 371-377.
- Vauth, R., Kleim, B., Wirtz, M., & Corrigan, P. W. (2007). Self-efficacy and empowerment as outcomes of self-stigmatizing and coping in schizophrenia. *Psychiatry Research, 150*, 71–80.
- Weiss, T. (2002). Posttraumatic growth in women with breast cancer and their husbands: An intersubjective validation study. *Journal of Psychosocial Oncology, 20*(2), 65–80.

- Wilbram, M., Kellett, S., & Beail, N. (2008). Compulsive hoarding: A qualitative investigation of partner and carer perspectives. *British Journal of Clinical Psychology, 47*, 59–73.
- Willig, C. (2001). *Introducing Qualitative Research in Psychology: Adventures in theory and method*. Buckingham: Open University Press.
- Windell, D. L., Norman, R. M. G., & Malla, A. K. (2006). Treatment and recovery in first-episode psychosis: A qualitative analysis of client experiences. *Schizophrenia Research, 86*, S141
- Woodward, C., & Joseph, S. (2003). Positive change processes and post-traumatic growth in people who have experienced childhood abuse: Understanding vehicles of change. *Psychology and Psychotherapy: Theory, Research and Practice, 76*, 267–283.
- Wright, E. R., Gronfein, W. P., & Owens, T. J. (2000). Deinstitutionalization, social rejection, and the self-esteem of former mental patients. *Journal of Health and Social Behavior, 41*, 68–90.
- Wunderink, L., Sytema, S., Nienhuis, F. J., & Wiersma, D. (2009). Clinical recovery in first-episode psychosis. *Schizophrenia Bulletin, 35*(2), 362–369.
- Yanchar, S. C. (2006). Beyond the qualitative–quantitative divide: How to proceed? *New Ideas in Psychology, 24*, 275–281.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health, 15*(2), 215–228. doi: 10.1080/08870440008400302
- Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J. A. Smith (Ed.) *Qualitative Psychology: A Practical Guide to Research Methods* (2nd ed). London: Sage Publications Ltd.

Zoellner, T., & Maercker, A. (2006). Posttraumatic growth in clinical psychology – A critical review and introduction of a two component model. *Clinical Psychology Review*, 26, 626–653.

Appendices

Appendix One Participants Demographic Sheet

You have been sent these questions because you have shown interest in taking part in the above study. Please answer the following questions as honestly as possible. The information will be used as a basis for the interviews and to provide general information about yourself. The data you provide will remain strictly confidential.

1. Age _____

2. Gender (please tick) Male Female

3. Residence (nearest city)

4. Would you consider yourself to have religious beliefs?

Yes No

a) If yes, what would you describe them as?

5. Are you currently in a relationship?

Yes No

a) If yes, how long have you been in this relationship?

6. Are you working at the moment?

Yes No

a) If yes, detail if part time, full time or voluntary.

7. Have you been diagnosed with psychosis or a psychosis-related disorder? (please tick – you will not be excluded from the study if you do not have a formal diagnosis)

Yes (go to question 9)
question 8)

No (go to

8. If no, have you experienced symptoms which are indicative of psychosis? (such as: *confused/disturbed thinking, false beliefs [delusions], hallucinations, changed feelings/feeling 'disconnected', changed behaviour or lack of insight during experience of psychosis.* Please tick)

Yes

Don't know

No

9. At what age did you first experience psychotic symptoms and how long have these lasted for (including relapsing)?

10. Would you describe your experience of psychosis as traumatic? (please tick)

Yes

Don't know

No

11. Have you used any services to help with your symptoms (please tick)

GP

Support Group

Crisis Team

Helplines

Counsellor

Mental Health Services

Psychologist

Psychiatrist

Social Services

Other (please specify) _____

12. Briefly write how your life has changed (positive and negative) as a result of your experiences with psychosis.

13. Is there any other information about yourself that is important for us to know prior to inviting you for interview e.g. any physical disabilities, use of interpreters etc?

If you would like to add any other information or if there is not enough room to complete your answers, please feel free to use the rest of this sheet.

Thank you for taking time to complete the above questions. Please send the completed form (along with the consent form) back to the researcher in the pre-paid envelope provided. You will be contacted shortly to inform you if you have been selected for interview and to arrange a time suitable to meet.

Appendix Two
Participant Interview Schedule

The interview will take a semi-structured format and based on the subject area, the following topics will be covered: experience of psychosis, traumatic response to psychosis, coping strategies used, key turning points during the traumatic psychotic experience and how the experience was subsequently viewed. It is important to include questions which investigate the participants' positive and negative experiences as growth cannot be understood on positive experiences alone. The types of semi-structured interview questions that will be used with the participants in the study are based on previous research in trauma and growth, particularly the study conducted by Woodward and Joseph (2003).

Semi-structured interview questions

Participants will be asked a general opening question about their experiences of psychosis. The following questions will only be used as prompts to avoid leading the participants.

Tell me what your experience of psychosis/hallucinations/voices has been like.

1. Please describe events prior to the onset of psychosis?
2. *When/how did your psychosis start?**
3. *What aspects of your experiences do you remember as being particularly traumatic/stressful?**
4. *Can you describe one particular traumatic experience which comes to memory and how that affected your life at that time?**
5. How do you feel about your experiences of psychosis?
6. In what way has psychosis affected your life?
7. How did you manage/deal with these traumatic experiences?
8. Have there been any key turning points (or changes) in your life, which you think have made a difference in terms of how you feel about your experiences?
9. Can you describe any changes within yourself that you attribute to the experiences you have had with psychosis?
10. How have your experiences guided your current outlook of the world, yourself and others?

All open questions will be followed up with prompt questions, depending on how much information the participants provide spontaneously.

** These questions formed part of the initial interview schedule and were intended to be discussed with participants. However, these questions were not used, as all participants discussed these areas without prompting or were covered when answering and expanding on answers to other questions.*

Appendix Three

Email sent to the local support groups/charities regarding details of the study and asking them about support to recruit through their groups.

Dear Sir/Madam

I am writing to enquire about the possibility of recruiting participants for my thesis through your website/ mailing list or if you could put me in touch with local support groups/member centres.

My name is [Trainee name] and I am currently in my 2nd year of the Trent Doctorate in Clinical Psychology Course based at Nottingham University. As part of the course, I am completing a piece of research which looks at people's experiences of psychosis and/or related experiences. I am particularly looking for people who have had a traumatic experience of psychosis (or related experiences – no 'diagnosis' necessary) and who have subsequently experienced personal growth or development as a result of their experiences. Most research into psychosis looks at the negative effects and I am interested in speaking to those people who have used their experiences to change their lives or outlook on life for the better.

I have received ethical approval for this study from the University of Nottingham. I am hoping to recruit around 8 people to interview for my study in an attempt to take a personal perspective and to detail the potential for development and growth even after negative experiences. I was wondering if it would be possible to recruit potential participants through your website/ mailing list or if you could put me in touch with local groups? I am happy to meet with people who live in Yorkshire, Nottinghamshire, Derbyshire, Lincolnshire etc (and possibly others). I have a research budget and will pay for any costs incurred for this.

Any help/advice you could give would be greatly appreciated. If you require any further information, please do not hesitate to contact me. I am happy to send you my research proposal and letter of ethical approval. I also have an advert to advertise the project along with a participant information sheet outlining the study in more detail and I would be happy to send you this information

Thank you in advance and I look forward to hearing from you soon

Kind Regards

[Trainee details]

Appendix Four
Participant Information Sheet

Title of Project: The Experience of Posttraumatic Growth in People with Psychotic Symptoms: A Phenomenological Approach.

We would like to invite you to take part in a research study, being conducted by [*trainee name*] (a Trainee Clinical Psychologist) as part of a required research component on the Trent Doctorate in Clinical Psychology course. 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 information carefully. Talk to others about the study if you wish.

Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study.

Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Part 1

What is the purpose of the study?

It is being increasingly recognised that a psychotic episode can be a distressing and traumatising event. Factors that may contribute to a traumatic reaction including being involuntarily admitted and the content of hallucinations/delusions. The person can develop symptoms which includes re-experiencing the traumatic event and avoidance of stimuli associated with the trauma.

Research has started to investigate the potential for positive growth and personal development that can occur after a person has experienced a traumatic event. Areas where a person may find new meaning and purpose that inspires them to positive personal change has been found in people experiencing bereavement, cancer, abuse and war to name a few. Until recently, most research in the area of psychosis has focussed on the negative consequences. There has been no previous research investigating the potential for people who have experienced traumatic reactions to psychosis to develop personally and grow. The aim of this study, therefore, is to discuss with people their personal experiences of growth after a traumatic episode of psychosis. It is expected that common themes in the stories of participants will emerge, which will help psychologists inspire and foster change and growth in their own clients.

Why have I been invited?

We are inviting members of the Hearing Voices Network and other psychosis support groups who have experienced a traumatic episode of psychosis and who have experienced personal growth or development as a result of this. You have been identified as someone who may be interested in taking part in this research.

We hope that by taking a personal perspective in this research, it will give you an opportunity to describe your story. These personal experiences will help to inform clinical psychology practice and it will also help to educate professionals who work in this area, to understand that personal development is possible in certain people.

We are hoping to include approximately 10 participants in this research. If a large number of people show their interest in participating in the study, then participants will be selected at random.

Do I have to take part?

It is up to you to decide. Read through this information sheet, which you can keep, and contact the researcher (details at the end of the form) with any questions you may have. If you would like to go ahead with the research, we will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason. This would not affect your participation in the Hearing Voices Network or any other group and will not affect the care you receive.

Expenses and payments

If you opt to attend the interview at The University of Nottingham, your travel expenses for this journey will be reimbursed. This will be based on the cost of public transport (receipts must be provided) or own vehicle costs (diesel/petrol) based on the mileage travelled as approved by the University of Nottingham.

What are the possible disadvantages and risks of taking part?

Although the research is focussing on positive development, you will also be asked to talk about experiences which you may have found traumatic or issues which are sensitive to you. You are not obligated to discuss anything which you find uncomfortable and you are able to stop the interview at any time. You will be given a debrief at the end of the interview session to explore the feelings you have after discussing your story and alternative support will be sought if necessary.

What will happen to me if I take part?

If you are interested in taking part, you will be asked to complete two forms, a consent form and a form which provides some information about yourself and your experiences, and return them to the researcher

in a pre-paid envelope. You will then be invited to attend one informal interview at a time and place suitable for you. The researcher will conduct the interview, either at a place convenient for you or at The University of Nottingham, which will last approximately 1 hour and during which you will be asked to describe your experiences. The interview will be recorded using an audio-recording device and the tapes will be stored in a locked cabinet. The tapes will then be transcribed by the researcher and typist, who will have signed a confidentiality agreement. Following transcription, the tapes will be destroyed and all data will be coded to ensure anonymity.

What are the possible benefits of taking part?

We cannot promise the study will help you, but it is expected that the information gathered in this research will add to a growing knowledge base of the potential for certain people to experience personal development, even after a negative traumatic experience. The results may help to inform the psychological profession of the potential for growth in some people after psychosis and may inform future interventions. It may also inspire others who have psychosis-related symptoms that growth is possible, even after a negative experience.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed, in the first instance, by the primary researcher, who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do so through the Trent Doctorate in Clinical Psychology Programme, University of Nottingham. Details can be obtained from the University of Nottingham.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with the study?

If you withdraw from the study, we will destroy all your identifiable data and you will not be included in the final write up.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions (details can be found at the end of the form). If you remain unhappy and wish to complain formally, you can do this through the Trent Doctorate in Clinical Psychology Programme, University of Nottingham. Details can be obtained from the University of Nottingham.

Will my taking part in this study be kept confidential?

The information you provide about yourself will be kept strictly confidential. The information used from your interviews, when the results of this research are written-up, will not include your name or other identifying details, to ensure you remain anonymous. The recordings of the interview will be stored for 7 years, according to University of Nottingham and Data Protection Act guidelines, and will then be destroyed.

What will happen to the results of the research study?

It is intended that these findings will be published, but your confidentiality and anonymity will be respected at all times. All participants will be provided with a copy of the finished report. If participants would like to see the results of their original interview, then you can request a copy and this will be sent to you.

Who is organising and funding the research?

The University of Nottingham is the sponsoring organisation of this study.

Who has reviewed the study?

The research has been reviewed by an independent review board from the Institute of Work, Health and Organisations, based at the University of Nottingham. The ethics committee has reviewed the study to ensure your safety, rights, well-being and dignity are respected. The review board have given approval for the study to be carried out.

Further information and contact details

Thank you for taking the time to read this information. If you require any further information about the study please do not hesitate to get in touch. If you decide to take part in the study, please contact the researcher who will be happy to discuss any further questions you have. You will also be required to sign a consent form, agreeing to take part, which you will be given a copy of for your records.

Appendix Five
Consent Form

Title of Project: The Experience of Posttraumatic Growth in People with Psychotic Symptoms: A Phenomenological Approach.

Name of Researcher: [Trainee Name]

Please initial box

13. I confirm I have read and understand the participant information sheet provided for the above study. I have had the opportunity to consider the information and to ask questions, and these have been answered satisfactorily.

14. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without any subsequent costs to me.

15. I understand that my interview will be recorded using an audio-recording device, and that anonymised use of my data may be used for verbatim quotation in the write up of this study. I give consent for my data to be used in this way.

16. I agree to take part in the above study.

_____	_____	_____
Name of Participant	Date	Signature

_____	_____	_____
Name of Person taking consent	Date	Signature

When completed, 1 for participant; 1 (original) for researcher site file

Appendix Six
Thank You Letter

[Participant Details]

Dear [Participant]

Hope everything is well with you. Thank you for taking part in my research. I really enjoyed speaking to you about your experiences and appreciate the time you took to do this. I've attached a copy of your consent form as we discussed the last time we met for you to keep for your records. I'll also keep you informed on how I'm getting on as the study progresses.

Please remember that if you need to contact me regarding my research, I can be contacted on [contact number]

Yours sincerely

[Trainee Details]

Appendix Seven Letter of Ethical Approval

Institute of Work, Health & Organisations

University of Nottingham
William Lee Buildings 8
Science & Technology Park
University Boulevard
Nottingham
NG7 2RQ UK
T: +44 115 84666 26
F: +44 115 84666 25
E: i-who@nottingham.ac.uk

Director

Professor Tom Cox CBE AcSS FBPSS
Hon FFOM (Dublin) Hon FErgS FRSH FRSA

DClin Psych Trainee
Dear [Trainee Name]

I-WHO Ethics Committee Review

Thank you for submitting your proposal on "The experience of posttraumatic growth in people with psychotic symptoms". This proposal has now been reviewed by I-WHO's Ethics Committee to the extent that it is described in your submission.

I am happy to tell you that the Committee has found no problems with your proposal and is able to give approval.

If there are any significant changes or developments in the methods, treatment of data or debriefing of participants, then you are obliged to seek further ethical approval for these changes.

We would remind all researchers of their ethical responsibilities to research participants. The Codes of Practice setting out these responsibilities have been published by the British Psychological Society. If you have any concerns whatsoever during the conduct of your research then you should consult those Codes of Practice and contact the Ethics Committee.

You should also take note of issues relating to safety. Some information can be found in the Safety Office pages of the University web site. Particularly relevant may be:

Sections 6.9, 6.10, 6.11, 6.14 of the *Safety Handbook*, which deal with working away from the University.

<http://www.nottingham.ac.uk/safety/>

Safety circulars:

Fieldwork P5/99A on <http://www.nottingham.ac.uk/safety/publications/circulars/fieldwk.html>

Overseas travel/work P4/97A on

<http://www.nottingham.ac.uk/safety/publications/circulars/overseas.html>

Risk assessment on <http://www.nottingham.ac.uk/safety/publications/circulars/risk-assessment.html>

Responsibility for compliance with the University Data Protection Policy and Guidance lies with all researchers. Ethics Committee approval does not alter, replace or remove those responsibilities, nor does it certify that they have been met.

We would remind all researchers of their responsibilities:

- to provide feedback to participants and participant organisations whenever appropriate, and
- to publish research for which ethical approval is given in appropriate academic and professional journals.

Sincerely



Dr Nigel Hunt BSc (Hons) PhD CPsychol AFBPsS
Associate Professor
Chair, I-WHO Ethics Committee

Appendix Eight
Sample of a transcript with the analysis for 'Eddie'

Text in bold signifies important words which were highlighted by the researcher during the analysis of the text

Description			Transcription	Interpretation
			E = participant I = Interviewer	
diagnosed/ labelled? - chronic schizophrenic never work again lack of understanding	56	E	yeah. When I first went in I was told I'd got erm I was told I was a chronic schizophrenic I would <u>never ever</u> work again and to go away and enjoy my life and erm and I <u>actually</u> believed it and I had no insight into mental health. I was ignorant to mental health services erm	impact of diagnosis loss of hope for the future
	57	I	as a lot of people are though aren't they	
Given medication making sense of voices ignoring voices	58	E	That's right and I kept taking these drugs I were on 25 different drugs a day and the voices was now really screaming erm and I can understand why the voices got really aggressive and angry now I couldn't at the time. It's because they wanted to be heard [1].	impact of medication sense-making
	59	I	yeah	
difficulty in making sense of voices lack of understanding by others? coping strategies	60	E	Actually, the voices were trying to be helpful. Although the content was negative I was <u>perceiving</u> it as negative [1] but I missed that for ten years and I'd be a revolving door patient and er eventually me wife threw me out and I lived on the streets for a while er [2] and I got me own place but it wasn't furnished or anything and er but eventually me parents helped me sort sort all that side of it out. And I went through so many weird experiences and erm y'know a lot of visions and [1] the emotional shut-down and suicide attempts and god knows what else. But all the time me focus were me	sense-making impact of mental health system coping hiding aspects

hiding symptoms – fear of lack of understanding ?			kids. I had this fear that something was happening. And I've been through some really mad mad states and er I always managed even if it were only for five minutes when I went to see 'em put this mask on and so I could see 'em like	of self
	61	I	umm	
children are important Positive relationship with OT	62	E	They were always a focal point [2] er and I got a very good worker after about six years in the system er called 'S' [<i>name</i>] she was an occupational therapist and she was like a breath of fresh air	supportive relationship
	63	I	was she?	
focus on individual – not diagnosis Fear of close relationships – scared of being hurt by women	64	E	Because she never <u>ever</u> treat my diagnosis and erm I don't let people into my life very easily because I've been hurt, especially <u>women</u> y'know as you can imagine and er but she what she did she just looked beyond it she said y'know you're names 'E' you're not a schizophrenic	Developing trust feels accepted?
	65	I	umm	
feeling understood through shared experiences/ understanding supported self-abusing	66	E	But she also told me a bit about herself what stresses and pressures she'd had in her life and I thought wow this woman does understand [1] 'cos I'd always seen workers as robots with no feelings and emotions like and er she was so kind to me and she helped me resolve the problems like I'd isolate myself on a Friday evening [2]. The voices would drive me crazy and I'd do stupid things and she says <u>why</u> do you do it? You were abused on a Friday you're self-abusing by putting yourself in this situation. We looked at why I did it and she <u>even</u> she said y'know you know where I live, come and see me on a Friday if you want, which is unheard of in the system I know	shared understanding trust - supportive relationship making sense acceptance/ belonging

	67	I	umm	
<p>someone to rely on</p> <p>support helped him to move forward</p> <p>feeling listen to</p> <p>trusting others</p> <p>'drugs' impacting on ability to function</p>	68	E	<p>And I <u>only</u> ever went twice and I had a glass of wine with her and her partner and I left but I wouldn't abuse it but I knew she was there then. And that were a big catalyst in starting to to move forward and then er I got another psych I got a new psychiatrist called 'P' [<i>name</i>] and he was nice but he listened as well and er he'd say if you need to see me and you haven't got an appointment just knock on my door. If there's nobody in come and see me. And he's reduce my medication a little bit [1] and er so things were picking up but I'd still not no real understanding as what it were but I <u>had</u> let someone into me life which was a turning point and I was trying to make sense of these experiences. But the problem was that I was on <u>that</u> much drugs I couldn't get me mind to function and process information</p>	<p>feeling supported/ accepted</p> <p>positive changes</p> <p>accepting of others</p> <p>medication controlling mind</p>
	69	I	umm	
<p>encouraged to attend support group</p> <p>mental health impacting on ability to function day-to-day</p> <p>view of schizophrenia challenged</p>	70	E	<p>And then a social worker that me wife got he rang me one day and said did you know there's a [<i>name of group</i>] group at [<i>place name</i>] and I said no and he said d'you wanna go so I says no but he did encourage me to go and I'd gotten to a situation where I didn't wash and didn't shave, I was scruffy y'know the archetypical schizophrenic thing. [2] And I went to this group and there were ten people there and the first thing that struck me was they were all smart and presentable</p>	<p>challenging own perceptions of mental illness</p>
	71	I	umm	
<p>shared experiences</p> <p>sense of belonging</p> <p>feeling</p>	72	E	<p>And I'm thinking well you can't be schizo you should be scruffy like me and er they were really kind and they started talking about their experiences and I though <u>wow, this is where I belong</u> [2] I can take this</p>	<p>group support</p> <p>acceptance and belonging (due to shared</p>

accepted? developing belief self process of discovery			mask off I can be myself even if it's only for an hour I can actually be who I want to be. And I realised the voices were quieter while I was there. I could <u>talk</u> about them and they weren't as threatening [1]. And it was like I was discovering myself y'know sort of like a process	experiences?) self-discovery (process)
	73	I	Was that the first time do you think 'E'?	
still doesn't know who he is	74	E	I think so I I I can sit here today and be be truthful with you 'I' and say I really honestly still don't <u>know</u> who I am	fragmented self?
	75	I	umm	
self is shaped by others and by society Loss of childhood (due to abuse)	76	E	I can tell you who people say I am and I can tell you what I've done with my life but in here I still don't know because I think the reason for that being is I lost a childhood. You can't ever get a childhood back	self defined by others/ experiences lost life
	77	I	yeah	
didn't fit into society as a child lost life due to 'system' and abuse – can't get the time back impact of others – aiding understanding	78	E	And the y'know all this schooldays happiest days of your life, not for me they weren't ' cos I didn't fit and erm really in my mind and really I should be twenty seven year old [1] 'cos I lost ten years of my childhood and I lost ten years in the system. So I should have I should only be twenty seven really y'know (laughs). Erm, and then they invited me to a workshop and er and three people from the [national organisation name] and they said something really profound that stuck in my mind. They started saying that the voices talked about events of your life	different? lost life/time? supportive relationships
		I	umm	

Appendix Nine:
Sample of initial clustering of themes for 'Eddie'

Text in bold signifies themes identified from sample transcript in Appendix Eight

Clustered theme	Examples of Interpretations in transcript
Impact of Abuse	re-experiencing memories of abuse guilt past influencing present
Multiple selves – disrupted self	hidden self fragmented self? self as defined by experiences/others
Control and Power	loss of control powerlessness
Coping	dissociating Self-abuse
Negative impact of psychiatric system	“revolving door patient” impact of medication loss of hope for future controlled by medication? impact of diagnosis
Impact of Relationships	supportive relationship power struggles in relationships relationships as destructive
Impact of Others	lack of understanding by others society as discriminating no sense of belonging
Responsibility	parental responsibility responsibility (for others)
The Integrated Self?	voices as part of self – the integrated self regaining self accepting the whole self
Positive Change Agents	supportive relationships developing trust shared understanding acceptance/belonging self-discovery (process) regaining control sense-making
Positive changes - Growth	helping others accepting of others accepting voices self-acceptance journey of self-discovery
Impact of psychosis	paranoia multiple losses re-traumatised

Appendix Ten:
List of overarching themes for all participants

This is made-up of the clustered themes taken from all participants and re-clustered according to similarity of content (as demonstrated in Appendix Nine)

Clustered Themes	Overarching Theme	Participants (n=7)
Impact of Relationships Impact of Others Duality of relationships Stigma Negative appraisals by others The psychological impact of diagnosis	Relationships with others Supportive other Negative others	7
Psychological impact of experiences Multiple losses Loss of future Changing self Battling with symptoms Impact of voices	Negative impact of psychosis	7
Negative impact of psychiatric system Control and powerlessness	Negative impact of the mental health system	6
Coping	Coping	3
Acceptance/Belonging	Acceptance/Belonging	6
Psychological impact of trauma Abuse Control and powerlessness	Psychological impact of trauma	4
Responsibility	Responsibility	3
Positive change agents	Supporting others	7
Positive changes Integrated self Changing self Positive psychological changes Contemplating life Change as ongoing – journey Beyond recovery	Growth/positive change/recovery Changing self	6
Regaining control	Inner strength	5
Sense-making Self-discovery	Finding meaning and purpose	

Themes removed from final groupings included responsibility and coping (minority of participants discussed this – low frequency within participants' stories) and impact of trauma (mainly discussing previous abuse – did not add to the understanding of change in people with psychotic symptoms – discussed within the subordinate theme of impact of psychosis in terms of re-traumatisation).

Appendix Eleven:

A further level of interpretation allowed the overarching themes to be grouped according to sub-themes (reflecting negatives, positives and changes). These were then clustered under three dominant superordinate themes. The participants' endorsement and examples add to the audit trail.

Superordinate theme	Subordinate theme	Example quote	Participants (n=7)
Barriers to change	Stigma/lack of understanding/negative others	a lot of the time I've got to say to myself I'm never going to get back to work 'cos there's a lot of discrimination out there and what do you tell somebody you've done in the last 13 years? (Gary, 116)	7
	Negative impact of psychosis	I have lost a lot of time having psychosis, erm time that I can't get back and erm that makes me disappointed and angry (Adam, 78)	7
	Negative impact of the mental health system	I don't need, always need hospital admission I just need somewhere to go that's safe, it doesn't need hospital. It makes it worse (Cathy, 142)	6
The Adapting Self	Finding meaning and purpose	So those were two voices from my family and I looked at them and learnt (Beth, 119)	6
	Support and understanding	I thought there'd only be about one there and that'd be me. But it weren't, there was twelve of us there that day...and that cheered me up it meant at least twelve people knew what your illness was (Derek, 398/400)	7
	Inner strength and determination	So one day all I did was face her down in the street...And she wouldn't look at me. And I thought this woman's got no hold over me but as I did that the voices went very quiet (Eddie, 144/146)	6
	Self-acceptance and awareness	I wouldn't want anybody to go through it, but you realise how much you can achieve and how much you come through, come through the other end and actually it be positive and how much more there is to do, how much more there is in the future... but I've learnt so much and I've come a long way (Cathy, 256)	5