

Psychophenomenology of the Postpsychotic Adjustment Process

Mary D. Moller and Jaclene A. Zauszniewski

A clinical phenomenological study with nine adults with schizophrenia explored the postpsychotic adjustment stage of recovery from a psychotic episode to map a psychological recovery trajectory. Participants (ages 21–37 years) were actively involved in an early psychosis outpatient treatment program. Psychophenomenological analysis of interview data resulted in 458 descriptive expressions reflecting four structural elements. Cognitive dissonance involved achieving pharmacological efficacy and cognitive efforts to sort out the experience. Insight was distinguished by mastery of autonomous performance of reality checks. Cognitive constancy was marked by resuming interpersonal relationships and age-appropriate activities. Ordinariness involved consistent engagement in daily activities reflective of pre-psychosis functioning.

© 2011 Elsevier Inc. All rights reserved.

THE ONSET OF schizophrenia is an overwhelming and frightening experience for the patient and family members alike. Schizophrenia is an illness with a highly variable recovery trajectory (Tandon, Keshavan, & Nasrallah, 2008). Although the recovery movement has inspired many providers, family members, and persons with psychiatric disabilities and great progress in modernizing treatment has occurred, there are still many people with serious and persistent mental illness who have poor adjustment to psychosis. The potential for relapse is unpredictable and can create uncertainty regarding how to proceed with life. This uncertainty can make coming to terms with the illness and adjustment to life with psychotic symptoms difficult. To date, there are no postpsychosis adjustment roadmaps or established clinical milestones to guide the person and family in the psychological process of recovery from psychosis. The absence of an identified psychological recovery trajectory creates frustration for the person, family, and providers. Therefore, mental health professionals are unable to give good guidance to the person and family on the process of postpsychotic psychological adjustment to schizophrenia.

The research question addressed in this qualitative study was: “What is the experience of persons with schizophrenia in the postpsychotic adjustment stage of recovery from psychosis?” The first aim of the study was to investigate the cognitive processes and structural elements of how a person with schizophrenia psychologically adjusts to life postpsychosis. The second aim was to map a psychological recovery trajectory by identifying key recovery milestones and characteristics. The purpose of this article is to describe the results of applying van Kaam’s (1987) psychophenomenological method

From the Psychiatric-Mental Health Nursing, Yale University School of Nursing, New Haven, CT; Frances Payne Bolton School of Nursing, Case Western Reserve University, Cleveland, OH.

Corresponding Author: Mary D. Moller, DNP, APRN, PMHCNS-BC, CPRP, FAAN, Associate Professor, Specialty Director, Psychiatric-Mental Health Nursing, Yale University School of Nursing, 100 Church Street South-Room 235, New Haven, CT 06536.

E-mail addresses: mary.moller@yale.edu (M.D. Moller), jaclene.zauszniewski@case.edu (J.A. Zauszniewski).

*© 2011 Elsevier Inc. All rights reserved.
0883-9417/1801-0005\$34.00/0
doi:10.1016/j.apnu.2010.10.005*

(PPM) to the study of postpsychotic adjustment in persons with schizophrenia.

LITERATURE REVIEW

Stages of adjustment to chronic medical illnesses have been well described in the rehabilitation literature, whereas the processes used by adults adjusting to living a life with an illness and coming to terms with a diagnosis that includes psychosis as a symptom has not been well understood. Prior to this study, the concept of psychological adjustment to psychosis has received minimal study. However, the need for interaction between person and environment to facilitate psychosocial adjustment postpsychosis had been validated (Forchuk, Jewell, Tweedell, & Steinnagel, 2003; Mishel, 1988; Verdou, Husky, Tournier, Sorbara, & Swendsen, 2003). Birchwood, Todd, and Jackson (1998) incorporated the concept of psychological adjustment following a psychotic episode into their study of interventions critical for individuals experiencing the first break of psychosis. This study did not define psychological adjustment but looked at the concept as a means to attaining psychological well-being. The answer to the question "What kind of adjustment should be the aim?" was acceptance of illness, mastery over illness through education, symptom management, early recognition of relapse, and dealing with stigma (Birchwood et al., 1998, p. 57). The relationship of personal coping styles to psychosocial adaptation to disability was studied by Livneh and Wilson (2003).

In a qualitative study of young adults aged 17–24 years, four stages in the recovery process were identified using grounded theory: emergence, loss, adaptation/adjustment, and recovery/reintegration with adjustment as the end process of adaptation (Leavey, 2005). Adjustment included the ability to create a new sense of life meaning, learn new skills based on a new intellectual and emotional reality resulting from being given a psychiatric diagnosis, cope with loss and confusion stemming from the pain of alienation, attain insight into limitations, demonstrate a future orientation, have hope, establish new goals, obtain work, and finish desired education (Leavey, 2005). Other literature subsumes adjustment into adaptation rather than attempting to delineate the subtleties that differentiate the concept of adjustment from the larger construct of adaptation.

Davidson (2003) proposed a comprehensive model of living with and recovering from schizophrenia that offers views of both the internal and external lived experiences based on more than 100 open-ended qualitative interviews. Distilling the experiences described, life on the inside of schizophrenia progresses from life before the illness, to withdrawal and isolation, to the experience of cognitive intrusions and disruptions, and ultimately ends in a decline in the ability to function. Life on the outside is a process that begins with somehow making sense of the intrusions and disruptions, experiencing belonging and hope, achieving an enhanced sense of agency, and culminates in active efforts at coping and adaptation demonstrated by increased community involvement (Davidson, 2003).

Persons with schizophrenia who have poor postpsychosis life adjustment reflect a population characterized by poor symptom management, poor adherence to the medical regimen, perceived or real lack of social support, inability to maintain employment, and frequent relapse (Torrey, 2006). These individuals commonly report ongoing fear of relapse, fear of rehospitalization, and an overwhelming sense of lack of control (Lunt, 2002; Worcester & Moller, 2003). They might also experience an inability to cope with the demands of life and the devastating stigma that is experienced (Deegan, 1990; Lunt, 2002). The hope of achieving prepsychosis life goals might be lost, and this group of people with schizophrenia becomes "stuck" in the "revolving door" of relapse, hospitalization, and additional deterioration, often resulting in incarceration (Birmingham, 1999; Gastal et al., 2000; Rabinowitz, Mark, Popper, Slyuzberg, & Munitz, 1995; Torrey, 1995, 2006).

Poor postpsychotic adjustment often mimics relapse, and individuals are hospitalized unnecessarily, endure frequent medication adjustments that do not relieve symptoms, and experience a sense of overwhelming failure (Microulis, 2004). Ultimately, these persons with schizophrenia withdraw from social events and relationships, stop progress toward achieving life goals, express a loss of spirituality, feel hopeless and powerless over their illness, and verbalize an overall poor quality of life (Deegan, 1990; Lunt, 2002). This cohort of individuals with schizophrenia incurs the bulk of the costs associated with schizophrenia (Weiden & Olfson, 1995).

Prior to this study, no empirical data had been reported that explored the internal experience of adjusting to the life changes created specifically by the catastrophic illness of schizophrenia and the traumatic aftermath of psychosis. No research had been reported that identified critical health care interventions that might be required to initiate the adjustment process for persons with schizophrenia. This study identified a process of how nine people with schizophrenia make sense of the intrusions and disruptions that was inferred by Davidson (2003).

METHODOLOGY

To study postpsychotic adjustment in people with schizophrenia, it was deemed necessary to recruit a sample of individuals who were no longer experiencing acute psychosis and were actively involved in a postpsychosis recovery program. Following university institutional review board approval and in compliance with the 1996 Health Insurance Portability and Accountability Act (HIPAA) privacy standards, a recruitment flyer explaining the study was distributed by the program director of an early psychosis intervention program (EPI) in the Pacific Northwest to all agencies served by the EPI. The flyer explained the study inclusion criteria, interview probe questions, and contact information of the researcher. Potential participants were informed they would be interviewed individually for 1 to 2 hours at the beginning of the study, that one third of the sample would be randomly chosen to attend a focus group (member credibility check) midway through data analysis, and that all participants would be invited to a focus group at the end of the study to review the final data analysis. Participants would receive a \$10 coffee gift card after the initial interview and again at the midway focus group; at the final focus group, a light meal would be served. Adhering to HIPAA guidelines, interested participants were asked to contact the program director, who arranged for an initial orientation session with the researcher. At the completion of the orientation session, individuals agreeing to participate in the study signed an informed consent and completed a demographic questionnaire. Total time involved in the orientation session and completion of the demographic questionnaire was approximately 1 hour prior to beginning the formal tape-recorded interview.

Inclusion Criteria

Participants met the following inclusion criteria: at least 21 years of age with a diagnosis of schizophrenia or schizoaffective disorder according to criteria published in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (American Psychiatric Association, 2000); active enrollment in the EPI program for at least 1 year; able to speak conversational English; possess a high school diploma or general education equivalency or were actively participating in a program leading to attainment of high school education; and presence of reality-based decision-making capacity. *Decision-making capacity* was defined as mental status with minimally active psychotic symptoms that did not interfere with conversational ability; orientation to person, place, time, and self; and active participation in program activities. Verification of adequate decision-making capacity was established first by agreement of both the participant's case manager and psychiatrist at the time of the study recruitment and second by the participant's ability to engage with the researcher to complete the demographic assessment during the orientation session.

Data Collection

Participants were interviewed in a private setting for 1 to 2 hours, with the interviews openly tape-recorded. The following probe questions were asked:

1. What has your life been like since you had a psychotic episode and were diagnosed with schizophrenia?
2. Since having a psychotic episode and receiving the diagnosis of schizophrenia, what does adjustment to life mean to you? This question was amplified by asking "What changes in your life have you had to make because of schizophrenia?"
3. Describe the points in time that have been important to you in adjusting to life since your psychotic episode.
4. Was anything missing from your treatment that would have helped in your adjustment to having a psychotic episode and being diagnosed with schizophrenia?
5. Is there anything else you would like to tell me?

The interviews were then transcribed, resulting in approximately 40 typed pages per interview.

Four transcriptions were randomly sent to the program coordinator to be sent to the participants to determine trustworthiness and accuracy of the transcription.

Sample Demographics

The generally small sample size in a phenomenological study is determined by the researcher as the number needed to generate repeating statements (Polit & Beck, 2006). A volunteer convenience sample of persons with paranoid schizophrenia ($n = 5$) and schizoaffective disorder ($n = 4$) was recruited from the EPI. In this study, statement repetition occurred after four participants were interviewed. The study sample consisted of six males and three females with an average age of 27 years (range = 21–37, $SD = 5.64$). Ethnicity included six Whites and three Hispanics. The average age at diagnosis was 22 years 4 months (range = 19–31, $SD = 4.13$). This study was conducted in the fourth year of existence of this EPI. The agency requested that a representative of the original graduates of the program (who had prior treatment elsewhere and also had a late-onset diagnosis) because of the experiences and reflections that would be contributed. This participant skewed the average age of onset and age of participants that would normally be in a sample of individuals recovering from the first episode. The EPI also requested representatives of each phase of the EPI be included. Eight had graduated from high school, one had achieved the general educational equivalency, and two had graduated from college. Three were currently enrolled in a local community college. Three were working part-time, and two were volunteering. None were married. No one was actively psychotic at the time of the study. A total of 157 hospital days had occurred for this sample prior to enrolling in the EPI and none subsequent.

Each participant emphasized the importance of taking medications as the most essential treatment component for achieving stability. Of the seven currently taking medications, each was prescribed a unique combination of two to six prescriptions to maintain stability. Two required two antipsychotic medications to manage acute symptoms. One participant required only one prior antipsychotic prior to achieving symptom remission. Four participants had been on two prior antipsychotic

agents, three had been on three, and one had been on four before achieving enduring symptom stability. Six participants were also taking antidepressant medications, four were prescribed anti-anxiety agents, and two were prescribed a mood stabilizer. No participant was taking the originally prescribed medical regimen.

Data Analysis

Clinical phenomenology “looks for the meaningful organization of the other’s experiences, expressions, and behaviors, pointing to the narrative understanding of the other” (Stanghellini & Ballerini, 2007, p. 134). Psychophenomenology, as developed and described by van Kaam (1987), attempts to describe and scientifically analyze the internal psychological structures of the human experience by means of a phenomenological approach similar to Edmund Husserl’s articulation of pure consciousness resulting in the necessary and essential constituents (structural elements) of a phenomenon.

The basic principle of the PPM is the disclosure of the essential structures of human experiences as manifested in the framework of the situation in which they are perceived (van Kaam, 1987, p. 106). The PPM begins with prescientific descriptions from a number of participants. This represents a major departure from the traditional psychological perspective of viewing behavior through the lens of a particular psychological theory espoused by the researcher. Participants are asked to describe the situation in which they experience a psychological phenomenon, and the PPM then relates the psychological experience directly to the life world of those questioned (van Kaam, p. 105). The PPM ultimately produces a more general description of the structure of the psychological experience of the participants. From this description, the eidetic reduction is accomplished.

Psychophenomenology is a reflective and intuitive 12-step directed process that happens in four stages: analysis, translation, transposition, and phenomenological reflection (Anderson & Eppard, 1998). The four stages include the operations of listing and preliminary grouping of potential necessary and essential constituents, reduction, elimination, hypothetical identification, application, and final identification. The data are classified according to the frequency of occurrence, and the ranking is verified by a panel of judges. The number

of potential constituents is then reduced to eliminate overlapping, vague, or intricate categories, and agreement of an external panel of judges is again sought. This systematic approach to identifying the psychological perception of a lived experience closely parallels the psychotherapeutic process; as such, the PPM is readily adaptable to studying the experiences of people with schizophrenia. This method was selected because of the quantification process that occurs between the researcher, the narratives, and the independent panel of judges. The

panel of judges was composed of three seasoned nurse researchers.

RESULTS

The narrative interviews were composed of 458 descriptive expressions that were categorized and reduced to 50 characteristics of psychological adjustment to psychosis: cognitive (*n* = 17), interpersonal (*n* = 11), emotional (*n* = 17), and physiological (*n* = 6; Table 1). The descriptive expressions were then reduced to four essential

Table 1. Postpsychotic Adjustment Structural Elements and Characteristics

Milestones	Structural elements			
	Cognitive dissonance	Insight	Cognitive constancy	Ordinariness
			Characteristics	
Emotional component	Embarrassment	Learning how to cope with life now	Importance of having a positive initial hospital experience	Be able to think about the future
	Fear		Someone to be there for me (support system)	Accomplish life goals
	Lost self-confidence		Something to do with my time	Have my own place to live
	Frustration		Treatment environment that feels safe	
	Could not handle stress		Reassurance/encouragement	
Cognitive component	Fear of saying something wrong	Trying to figure out thoughts	Not having too much quiet time	
	Confusion	Doing my own reality checks	Being around people	Manage my symptoms
		Getting control of my symptoms	Having hope it will get better	Something to distract from the symptoms
		Getting used to it	Accepting that I need treatment	Finish education
		Recognizing limitations	Getting back to what I used to do	Become employed
Interpersonal component	Hard to go out in public and be around people	Can communicate with others	Think positive	
			Learning I am not the only one with schizophrenia	
	Lost my friends		Being given choices/control in my treatment	
			Have someone listen to me/understand me	Do what other people do
			Someone to talk to about me	
Physiological component	Takes all my energy	Took time to stabilize from first episode	Confidence in the counselor/therapist	
	Used drugs and alcohol		People need to be honest with reality	
			Having people explain things to me	
		Someone to talk to about general things		
		Having help available when first get sick		
		The right medication		
		Taking care of my body		
		Having a routine		

Table 2. Breakdown of Characteristics by Milestones

Milestones	Responses	Characteristics
Emotional	159	17
Cognitive	135	16
Interpersonal	106	11
Physiological	58	6

structural elements: cognitive dissonance, insight, cognitive constancy, and ordinariness. These elements and characteristics of postpsychotic adjustment can be used as trajectory milestones and treatment goals to document movement toward adjustment (Table 1) and treatment goals (Table 2). The emotional component was dominant in cognitive dissonance, whereas the cognitive component was dominant in insight. The emotional and cognitive components were equally dominant in cognitive constancy and ordinariness; however, the interpersonal component was only dominant in cognitive constancy (Table 3).

Cognitive Dissonance

The element of cognitive dissonance is defined as a state of being in which a person experiences conflict and personal distress because of a perceived inconsistency between two beliefs. Typically, one of the beliefs is known and the other is not known or has not been experienced. The discord between the beliefs results in behaviors that are incongruent with previously held attitudes, values, emotions, or beliefs (Festinger, 1957). Measurable outcomes included a consistent reduction in psychotic symptoms resulting in diminution of emotional, interpersonal, cognitive, and physiological states. Resolution of this phase was dependent on pharmacological efficacy and family support. The length of time to achieve resolution ranged from 6 to 12 months.

In the phase of cognitive dissonance, participants became aware they were not functioning in everyday life in the same manner as their peers but were unable to effect change on their own. They had engaged in treatment, often passively, but symptoms had not been stabilized. This element

Table 3. Comparison of Characteristics by Constituent

	Cognitive dissonance	Insight	Cognitive constancy	Ordinariness
Emotional	5	1	8	3
Cognitive	2	5	6	3
Interpersonal	2	1	7	1
Physiological	2	1	3	0

took months of self-imposed isolation at home, during which participants rarely “left the couch or bedroom” while trying to “sort out” what had happened. It was a very personal and highly emotional cognitive process of trying to discern between reality and psychosis that resulted in recognizing the difference between their internally driven symptoms and external reality.

P7: I was scared most of the time because of the fact I didn't know if what was going on in my head, was really going on in the world and not knowing that wasn't normal. And that there wasn't really things happening to me.

P4: For several months I had to just lay on the couch and play my game. It was kind of like writing a story, really. You just come up with things to think about and—I mean, some word—some of it might be inappropriate to write about but you might—like, cuss a lot and see if that makes it go away. When you're playing those games in your head it's like somebody encouraging you, is what the feeling is like.

Participants wrestled with recognizing the effects of psychosis-driven cognitive dissonance on self-concept and their ability to function in ordinary life. The recognition of symptoms resulted in finding it difficult to be around other people and embarrassment. Participants described being too busy with thoughts to be able to speak to friends, as well as not being able to believe people whom they had previously trusted. Not wanting people to know that symptoms were occurring was the rationale for dropping out of school or quitting work.

P2: I hadn't talked to anybody for about a year. I didn't want to talk to people because they might think there's something wrong with me.

P4: Eventually I wasn't scared of me anymore and I could sleep later [sic]. It just took time. That's all it was. I was wondering how long the voices were going to keep going. But once they stopped I was fine, and I got—I started to adapt to that kind of experience. I mean, it only took me a couple months to really get used to it. And I only got used to it because I quit my job. And I stayed at home and laid around on the couch trying to adapt to the experience.

P5: I was too busy with my thoughts in high school to speak to any friends. I lost friends because I lost touch with reality—lost contact with my closest friend because I couldn't talk to her because my thoughts wouldn't let me talk.

Insight

The recognition that illness symptoms are indeed pathological and have created serious consequences

in all aspects of life is the hallmark of the element of insight. The ability to understand the origin and progression of symptoms and to internalize and verbalize the consequences of the symptoms also occurs. Measurable outcomes include the ability to master the process of conducting reliable reality checks, demonstrating the ability to “get used to it,” coping with life now, and reestablishing the ability to communicate with others. Resolution of the phase of insight was dependent on medication efficacy, family support, and an understanding treatment team. Length of time of resolution was 6–18 months.

During development of insight, participants were struggling with the consequences of the devastation of psychosis while attempting to accurately perceive the reality experienced by others by trying to understand what had happened and was currently happening to them. The outcome of this element was mastering the skill of how to independently perform reliable reality checks. The ability to gain insight was influenced significantly by medication efficacy. Dominant characteristics included becoming accustomed to having symptoms, learning how to cope with them in a uniquely personal manner, and learning how to communicate with others again. Only when communication with others resumed on a more frequent basis was stability achievable.

P3: You know sometimes I'll say just enough that I'll know it's weird, but not quite let everybody know exactly everything and just see what they do with it.

Participants focused on the need to separate the sense of the well self from the ill self and to learn how to think less negatively, thereby regaining some positive sense of self-esteem. The ability to assign causality to symptoms has been reported to affect self-esteem only in relation to intensity and duration of symptoms and effect of stigma (Khang & Mowbray, 2005).

P7: I'm trying to get a different perspective on things. As soon as I start taking in other people's perspective I'm like, well I can do it just as good you know. I have to separate myself from the symptoms. That's the one big thing I think. I had to change the way I see things.

Participants also referred to a dawning awareness that life would be different now and that previously mastered tasks would have to be approached in a stepwise manner to be accomplished. They acknowledged the need to “take

back” management of their problems from those who had been assisting with acute caregiving. These responses indicate the importance of timing and intensity of intervention strategies (Wilson, Hobbs, & Archie, 2005). The ability to engage in communication with others marked a significant improvement from responses in the interpersonal component of cognitive dissonance that centered on the inability to talk to others. This achievement sets the stage to move forward. Responses denoted a sense of accomplishment in the recognition of being able to communicate better with people than before, particularly the ability to explain thoughts in a more lucid manner. Participants spoke of the ability to be logical and only say enough to recognize that psychotic thoughts were still operating as a way to self-monitor progress. There was a subtle shift from descriptions of altered communication processes that occurred in cognitive dissonance as participants gained confidence in the ability to engage in normal conversation.

The effect on family was first mentioned as participants recognized that family members had strong feelings and that arguments created by psychosis were now able to be discussed and understood by all involved family members. The extensive extant literature on the effects of schizophrenia on the family confirms the importance of the ill family member being able to talk with other members of the family in a logical and calm manner (Blanchard, Sayers, Collins, & Bellack, 2004; Brady, 2005; Torrey, 2006). Participants felt strongly that the characteristic length of time to stabilize from the first episode was physiological in nature. This was because they considered the ability to get back on track with their lives regarding work, school, and relationships in a physiological frame leading toward the ability to get up and leave the safety net of their homes. Eight described an extended period of 9–18 months after the first episode before they felt they had the courage to fully consider reengaging in ordinary life activities. During these many months, they were in the process of medication stabilization, gaining insight, and learning how to check reality so as to appear as normal as possible to their friends and family.

P4: The symptoms lasted a year and a half until I got on the right meds. It took me about a year of being lazy [laying on the couch]. After a year I just got better.

P6: I took about a year after I got on the right meds. After that I took things a lot slower, but they'd be like step by step, it'd be like a small step you noticed you'd be doing, you know, you'd be doing better in a certain thing and you'd want to be thinking, and I could sleep better at night.

P9: After the diagnosis everything was different—sometimes it's hard to do anything. Taking a shower is hard. Cleaning my place is hard. I went a year and a half with only brushing my teeth a few times.

Each described the ability to conduct reliable reality checks as the most important aspect of feeling safe to reenter society. Most had been able to establish how to test reality. A tedious, intricate, time-consuming, repetitive process was described that began with ascertaining that no one was actually trying to cause harm. Previously held beliefs felt to be true were discovered to be not factual. The next step was to actually rejoin people in the real world and continuously struggle to keep the psychotic reality in the background. By staying in contact with friends and constantly proving that thoughts had in actuality been delusional, a gestalt occurred and a return to normal life occurred with emphasis that the personal spirit was back. Next, ongoing reality checks would be conducted based on a desire to continually win the “game” that was initially “played” inside the head. The form of reality check would be to observe how others reacted to the person when he or she believed a certain sound had occurred. Participants reported finally getting off the couch and going to the local bus depot and just hanging out watching how others responded to them when they had symptoms. If others did not respond in a weird manner, then it was determined that others had heard the sound as well. If they did respond strangely to the participant's reaction, he or she would realize it was a hallucinated sound. Eventually, they were able to catalog psychotic symptoms and able to interact normally with others by reinforcing to self that a given thought or sensation was simply part of the ongoing, intermittent, psychotic symptoms and nothing that required responding to.

P2: I just try to really think about what's really going on. I finally caught on to the reality of everything. I'm not that special you know that the FBI would be interested in me.

P3: I was just hearing things and it wasn't like my mind wanting to do this or it wasn't my mind creating all this stuff. Once I heard it was up to me to react to it or not and what to do with it, you know, it was up to me, the whole

thing. If it was something, you know, if it was kind of a question or a statement or something, I would react. And then if other people heard it, hopefully they would to, you know, react or not react, that's kind of how it happened, I never got any reactions so, it was a kind of reality check.

The characteristic of ability to gain control of symptoms is different from the management of symptoms on an ongoing basis that occurs in the final element of ordinariness. Gaining control of symptoms actually referred to gaining control of how they responded to symptoms as opposed to being able to actually stop them. The ability to go out in public when symptoms were still occurring was important in being able to move forward. Expressions reflected that medications were helpful but did not totally eliminate the symptoms. Participants were now able to tell the difference between hallucinated sensory experiences and delusional persecution and could focus on behaving and acting in an ordinary fashion in spite of symptoms.

The ability to just get used to having schizophrenia reflected the importance of getting used to the symptoms as a precursor to being able to engage in ordinary activities of daily living. The importance of allowing for a necessary passage of time was described as participants ultimately realized that life for them was not going to be the same as it was before the diagnosis. One described the importance of realizing she no longer had to be afraid of herself. This remark was poignant in pointing out the personal devastation caused by the experience and the ongoing aftermath of psychosis. Overall, they described an ebb and flow of symptoms they could begin to predict. Ultimately, it took between 2 and 6 months to adjust to the presence of intermittent symptoms.

P1: I think it'd be strange to not have voices now 'cuz I've had them for so long they're just like this really intimate part of me, so not to have them would be just really weird. Normally when they're not loud it's not distracting. I'm kind of used to it, it's kind of normal for me.

Cognitive Constancy

A change to reality-based attitude and beliefs about illness resulting in stabilization of the emotional, behavioral, and cognitive incongruencies of psychosis occurs in the element of cognitive constancy (Festinger, 1957). Measurable outcomes included the individual's ability to

exercise strength and determination in reengaging in age-appropriate, school- or work-related activities. Resolution of this phase was dependent on a positive first episode of psychosis initial hospital experience, dependable support persons, effective time management, medication efficacy, and successful participation in interpersonal relationships characterized by enduring, meaningful conversations. Cognitive constancy was achieved in 1 to 3 years.

The 233 total descriptive expressions in this element contained nearly one half of all expressions in the nine interviews, thereby reflecting the predominant element of postpsychotic adjustment in this study. The change in attitude and beliefs began with the development of insight and was the driving force in their ability to engage in and verbalize desired components of treatment. As a result, daily functioning became consistent. Remarkable differences in the desire and ability to be around other people were noted, which contributed to further positive attitudinal shifts toward cognitive constancy. Because of the complexity of responses in this category, the characteristics will be described within the components of emotional, interpersonal, cognitive, and physical.

Emotional Characteristics

Fifty percent of the total expressions in cognitive constancy comprised the emotional category with predominant characteristics of having a positive initial hospital experience and presence of a dependable support system. Six persons described overwhelmingly negative effects of their initial hospitalization on the overall adjustment process, including a lack of being informed of what was happening, feelings of complete loss of control or powerlessness, and a perception that one should passively accept medication and be quiet. One stated he felt he was treated as an animal with rabies instead of a person. All participants grieved over the desire for staff to spend time talking with them, telling them about what was happening, and listening to how they felt about what was going on in their heads. This retrospective accounting indicates some reclamation of the emotional self that was temporarily lost during cognitive dissonance. The six who had negative initial treatment experiences also had the greatest difficulty gaining the confidence to reach out for help later in treatment.

P8: At one point I felt so powerless the only thing I could do because my arms and my legs were restrained was to look at the light and try to touch the light which was in the ceiling, with my tongue, because that was the only thing I could move.

Each participant made several comments regarding the meaning of having support (Champlin, 2009; Clinton, Lunney, Edwards, Weir, & Barr, 1998). The primary foci were on dependability on the family and the reliability of the EPI. Comments emphasized the importance of knowing someone was always available and that unavailability of staff might have resulted in rehospitalization or suicide. Study participants strongly expressed ambivalence in relying on family members for transportation, food, housing, and financial help, which was particularly distressing for those who left home to attend college or had graduated when the psychosis emerged and needed to return home to regain stability after the initial psychotic episode.

The characteristic of constructive use of time, which emphasized a shift in focus from oneself to other activities, such as working outdoors, pet care, or playing a musical instrument, was found to be distinct from the cognitive characteristic of something to distract from symptoms that is described later.

Participants also stressed the importance of receiving reassurance and encouragement that the loss of control was temporary and they would once again be a productive member of society within the context of having schizophrenia. All reflected on the value of being told they would not lose their skills or identity (Weiden & Havens, 1994).

P3: Reassure me that I'm going to be okay and that I'm still me and that this is only temporary and not what I'm going to be like for the rest of my life. One time my mom said to me, "I want my old son back" and I said to her, "He's in here somewhere."

A commonly accepted component of acute treatment is the provision of ample quiet time (Schiller, 1994). The transfer of this practice to the community setting often occurs during recovery. However, participants identified negative consequences of having too much quiet time, as quiet provided an opening for the return of unwanted symptoms. Premature promotion of independent living and encouraging solitude too early in the adjustment process can also exacerbate psychotic symptoms and delay attainment of cognitive

constancy. Once they moved to the element of reestablishing ordinariness, the provision of solitude was more important.

P1: Being alone makes it worse—being alone allows you to think more. Which sometimes thinking isn't very good. And then also, being alone, it sometimes can be stressful because it's quiet. Things happen, that wouldn't happen if you were with other people. Like my voices gets really loud when I'm alone.

Socialization emerged in this phase. Participants commented on the importance of being able to just “hang out” with others. One stated that he would go to the mall just to be able to see and be around people and to practice initiating conversation. Such actions show progress when compared to the isolation found in cognitive dissonance, and achieving progress in treatment instills hope, which plays a critical role in acquiring the tenacity to stay in and benefit from treatment (Hoffmann, Kupper, & Kunz, 2000; Salerno, 2002).

Interpersonal Characteristics

Essential elements of interpersonal communication focused on both the sender (talking) and the receiver (listening) (Boschie, Adams, Bromet, et al, 2000). Interpersonal communication characteristics that emerged in relation to the adjustment process focused on the ability of others to listen, to talk about everyday life, to discuss topics of interest to the participant, and to explain things in a comprehensive manner. Having a routine helped to regain a sense of control and autonomy. A helpful routine included getting up and going to bed at the same time each day and establishing set times for eating, personal hygiene, and exercise.

One third of the responses in this category described how being listened to, heard, and understood helped in the perception that their opinions mattered and facilitated return of self-esteem because they believed the mental health professional could validate their experiences.

P1: Just having someone listen to me is good. A doctor that listens to you that you can talk to. I don't know, get personal, you know. And listen.

Another important interpersonal characteristic was the relevance of the topic to the participant, or in their words, “someone to talk to me about me.” Responses focused on the isolation that was experienced when staff did not talk to them about

anything they knew or could make sense of. Similarly, discussing topics relevant to everyday life such as movies, sports, and the news was noted by participants as helpful. They reflected that such conversations indicated that the other person was okay with talking about something other than their symptoms and treatment. One stated that it helped her get to know the staff more as a regular person and conveyed a sense of normalcy by engaging in an everyday form of conversation. The need to understand what was happening to them and how helpful education about schizophrenia could be was emphasized in the characteristic having things explained by staff members. This aspect of treatment promoted a sense of confidence in the staff (Moller & Murphy, 1997; Randal, Simpson, & Laidlaw, 2003).

Cognitive Characteristics

Five succinct characteristics that describe active cognitive processes emerged: distraction from symptoms, acceptance of diagnosis and treatment to reclaim identity, use of positive thinking, regaining prior social skills, and having treatment choices. Seven participants described the dominant characteristic of having something to distract from the symptoms, which implied the ability to differentiate symptoms, stay present with reality, and engage in a cognitive process that would override psychotic symptoms. Helpful activities included composing music, actively talking back to the voices, calculating and taking PRN medications, reading, studying a foreign language, and being able to intentionally lie down and fall asleep without difficulty as compared to struggling to get to sleep. These activities differed from the passive strategies used to escape symptoms described in cognitive dissonance.

Acceptance of a diagnosis and the need for treatment were major steps in reestablishing a sense of identity (Frese, 1998; Kravetz, Faust, & David, 2000; Smith, 2000; Vallenga & Christenson, 1994). Accepting the need for treatment was described as a turning point and was closely related to the development of insight.

P6: I mean there's still things I'm going to have to jump over or whatever. But that's—I think everybody has to. The biggest step was to finally accept that I did have something wrong.

Another aspect of reclamation of identity was the characteristic of learning that “I'm not the only one

with schizophrenia.” The fact that participants were able to embrace the concept of universality facilitated the development of attachments to staff and other group members in spite of the recognition that schizophrenia is an illness laden with stigma and emotional impoverishment. These attachments in turn promoted reestablishment of identity and self-esteem (Walton, 2000).

P4: The doctor helped me understand that there were other people with schizophrenia and it's not just me. Our family—we talk about it and stuff. They are understanding when it's not like I'm the only person that has it. If I was the only person that had it, they probably wouldn't be very understanding.

The ability to think positive was uniquely captured by the statement “I no longer feel bad about myself.” A practical response was “if you let it get to you, it will.” These comments reflect significant progress and growth from cognitive dissonance.

Regaining skills that were available prior to the onset and treatment of schizophrenia is of critical importance for mustering the courage to reenter life. Getting back to “what I used to do” was a characteristic that indicated these participants had mastered basic habilitation, which had instilled courage to reengage in the pursuit of previous life goals or to embark on a new quest.

P3: After I started getting back into things, I got bored and knew I had to do something with my life. I started making truck payments on my own again after all of this.

The final cognitive characteristic was the importance of having choices in treatment. Participants reflected on how the collegial approach of staff facilitated negotiation. The importance of negotiating treatment was recognized as extremely helpful in regaining a sense of self-control (Archie et al., 2005).

Physiological Characteristics

All study participants identified the importance of getting on the right medication. The correlation between finding the right medication and overall improvement in cognitive function was recognized. Once medications stabilized the acute psychotic symptoms, they were able to think again, could begin to relax and feel peace, and experience an improvement in overall quality of life. No one described feeling embarrassed or stigmatized by taking medications.

P5: Now that medicines work I feel freedom and peace. Before medicine I woke up thinking oh no, I have to go through all of this again.

They also reflected on the importance of self-care activities, including sleep, exercise (i.e., Tai Chi), good nutrition, and elimination of alcohol and caffeine. Participants expressed benefits from having routines for promoting optimal sleep, exercise, nutrition, and personal hygiene, which enhanced their sense of control and autonomy. Considering the high comorbidity of medical illnesses in individuals with schizophrenia, it is important to emphasize health and wellness in the ongoing management (Brown, Inskip, & Barraclough, 2000; Chafetz, 1996; Moller & Murphy, 1997).

Ordinariness

The ability to consistently and reliably engage in and complete normal activities of daily living that are reflective of prepsychosis functioning occurs in the element of ordinariness. Measurable outcomes included successful enrollment in and completion of a desired course of study and/or successfully sustaining employment for 1 year. Resolution of this phase was dependent on an absence of a return to cognitive dissonance (relapse) and the ability to complete age-appropriate activities related to work and school and resolve a majority of the characteristics in the previous phases. Duration of ordinariness is at least 2 years. Achievement of ordinariness will not occur until the individual is functioning independently and is well on the way to achieving desired life goals. Only three participants were actively engaged in selected ordinariness activities.

At their current progress through the elements of adjustment, many of the participants' responses were phrased in the negative, as their appraisal of adjustment was yet to be achieved. There were, however, distinct characteristics in the interpersonal, emotional, and cognitive components. Only one reported feeling that ordinariness had really begun. Eight participants elaborated on the ability to have a future orientation as indicative of ordinariness. Both positive and negative expressions emerged, as some did not believe they could think about the future right now. Several were still experiencing feeling stuck in their current level of progress and felt there was considerable catching up to accomplish regarding school and employment before believing they had entered this element of

adjustment. They were reluctant to consider leaving the EPI.

P6: They were thinking about—about...taking me out of the EPI—and I don't—I think it's stupid because even though I'm back to—back to normal life right now, it hasn't been long enough, it hasn't been enough years before—you know, it's going to take a while, I think, and you just have to accept that.

The ability to accomplish life goals was deemed very important; however, no one had yet accomplished any desired life goals. The oldest reflected that she felt behind by 10 years in what she had previously hoped she would accomplish. A sense of chronic failure in achieving any goal since emergence of symptoms in the eighth grade was described by another. All felt they had compromised prepsychosis life goals and had basically just “gotten used to it,” including those who had graduated from the EPI.

P1: I wanted to do stuff by the time I was 37. Everything has come to a stop. I feel like I got cheated because I missed out on important milestones that I see my friends doing—I don't have that stuff. I wanted to buy a house—do those things that are supposed to have happened in your 30s.

Having independent living was a very important part of ordinariness. At the time of the study, three participants lived at home with at least one parent, five lived alone in an apartment, and one rented a small house. Each was comfortable in the current living arrangement. Those who were living at home with family expressed the desire to eventually move into their own independent housing.

The ability to do what other people do reflects the desire to achieve ordinary, age-appropriate activities that were being accomplished by peers. Responses reflected loneliness and frustration in having lost a significant amount of time from their lives. This was similar to the feeling of frustration expressed during the element of cognitive dissonance. A response related to fear of failure in relationships, yet having the desire to someday be married and have children, has been described as interrupted relational aspects of schizophrenia (Davidson, 2003; Walton, 2000). Being able to not have fear at the thought of going out with friends, having dinner, and totally stepping back into former reality reflects internal ambivalence represented by completing the element of cognitive constancy but not feeling confident enough to move

into the element of ordinariness (Sells, Stayner, & Davidson, 2004).

P9: If I'm adjusted I would be able to do all the things I think other people can do.

Symptom management and finishing education were discussed by eight participants. Depending on response to medications and length of time since first episode, responses centered around either achieving and maintaining stability or relief at not having to spend so much time thinking about having another psychotic episode. Recognition of the ability to be alone represents a giant step forward from cognitive constancy, in which it was deemed nontherapeutic to have too much alone time. Two had goals of achieving a master's degree. Three were contemplating community college or technical school. Three had completed college but were not working in their chosen fields. Each believed they would know when the timing was right to go back to school. The current reluctance of some to go to school was related to fear of failure that is consistent in the supported education literature (Cook et al., 2005; Ponizovsky, Grinshpoon, Sasson, & Levav, 2004).

P2: Getting stable and staying stable. I need to be more stabilized, you know. I'm so scared of psychosis happening again. That's why I want to make sure I keep taking my pills. I've never really come out of it again. I've been out of the hospital 3 years and I'm still not going out and doing the things I used to. I have to watch myself and make sure that I've taken the pills because if I don't it just starts over.

P3: I think about it [psychosis], but not every day. If it hasn't happened in a year and a half, I'll be alright, sometimes that's how I cope with things. I mean I know I can't avoid it all the time 'cause I do have little things that remind me of it and things. I do still hear things, talking and stuff, but I still feel normal.

All participants described the benchmark of becoming employed. Only four were currently employed either in a volunteer or part-time capacity. The stigma surrounding seeking employment with a diagnosis of schizophrenia was echoed by several participants. Recognizing that job coaching and supported employment are part of the EPI, they felt optimistic about eventually securing some form of desired work. Six specifically commented on the importance of meaningful work (Cook et al., 2008; Ponizovsky et al., 2004).

P4: My uncle has a welding shop. He wouldn't hire me now because I have schizophrenia and he doesn't suggest it. I haven't worked since the schizophrenia.

DISCUSSION

When a phenomenon is understood from the perspective of the one experiencing it, there is potential for greater empathy on the part of the caregiver and a deeper level of communication to occur. The final paradigm of postpsychotic psychological adjustment is described as a process that consists of (a) recognizing emotional, interpersonal, cognitive, and physiological states that indicate psychosis-induced *cognitive dissonance*; (b) gaining insight into the behavioral incongruencies resulting from psychosis-induced cognitive dissonance evident by emotional, interpersonal, cognitive, and physiological outcomes; and (c) achieving *cognitive constancy* through a change in attitudes and beliefs that produce resolution of the emotional, interpersonal, cognitive, and physiological incongruencies resulting in stability in all aspects of behavior, which (d) culminates in reestablishing *ordinariness*, the ability to consistently and reliably engage in and complete age-appropriate ordinary activities of daily living. It is important to stress that this process is dynamic, and participants can be in one or more phases at the same time.

Factors that delayed postpsychotic adjustment included extended length of time to achieve initial pharmacological symptom management, absence of active family support, absence of use of active listening communication skills by treatment staff, effects of stigma on the ability to accept the diagnosis, and impaired cognitive ability to achieve insight into the diagnosis. Unmet initial mental health care needs that contributed to delayed postpsychotic adjustment centered on the participant's perceptions of initial treatment regarding ability of treatment providers to emotionally engage in a therapeutic relationship and absence of availability of an early psychosis treatment program.

Aspects of treatment that helped postpsychotic adjustment included staff actively connecting with the participant to create a sense of safety in all aspects of treatment through the use of psychoeducation; the participant's ability to negotiate all aspects of treatment with program staff, which served to rebuild self-esteem and give a sense of

control as a result of a change in attitudes and beliefs; building on existing knowledge of symptom management strategies; promoting hope through use of encouragement; and overcoming stigma through reengagement in the education and work arenas.

Results of this study can be used to explain the often-confusing behavior of an individual struggling to come to terms with the devastation and aftermath created by a psychotic episode. In the element of cognitive dissonance, it is critical for providers and family members to recognize that a period of 6–12 months of basically “laying on the couch” is required for the individual to begin to differentiate reality from unreality. This finding might help treatment teams to understand why most persons with schizophrenia refuse or are unable to sustain the level of intensity of being forced into premature medication and activity groups. The person needs one-to-one support and the simple process of time to grasp what has happened. Interventions during this time should include support, encouragement, elimination of fear, and rebuilding self-confidence. It is also critical for providers to realize that until the person is able to initiate meaningful conversation with others, progress will basically be at a halt.

In the element of insight, the person often seeks to be around others but is not yet able to engage with others in a one-to-one relationship. This is the appropriate time for group social skills education and to encourage activities that enable the person to see if directions can be followed. It is crucial during this time for the individual to practice having psychotic symptoms in public to begin the tedious job of sorting out reality from unreality. It is not uncommon for persons in this element of adjustment to “hang out” in areas such as bus depots or street corners, often finding others who are going through the same thing. These individuals are struggling to fit in somewhere in society, experimenting with different ways of reacting to symptoms and seeing if it bothers others.

When ready, the person will seek out social arenas where he or she will be required to initiate meaningful conversation, such as going to a mall or grocery store. When the person can successfully interact with others in some kind of authority position, such as a bus driver or retail clerk, and achieve a personal goal of figuring out transportation or purchasing something from a store, self-

esteem and self-worth improve dramatically. At this point in the postpsychotic adjustment process, psychoeducation is requested and information more likely to be retained. The person now feels ready to muster the internal grit to resume or start school or some kind of vocational endeavor and begin achieving the tasks identified in the element of ordinariness.

A vast and exhausting amount of work is required to move through the four elements and progress from fear of saying something wrong, difficulty going out in public, and being around people to finally doing what other people do. Once these efforts are recognized and documented by providers and family members alike, the person can fully engage as an equal member of the treatment team and ultimately make a valuable contribution to society.

There are several limitations to this study. Because of a small convenience sample, the results cannot be generalized to all persons with schizophrenia. Participants were able to understand the origin and progression of symptoms and could internalize and verbalize the consequences of the symptoms, and their responses may not be applicable to other persons with schizophrenia enrolled in a first-episode treatment program or those unable to verbalize their experiences. The postulated trajectory of a postpsychotic adjustment process is not definitive, as other interpretations of the data can be made.

The cross-sectional design limits reliability of the participants to replicate their stories with the same insights and accuracies. In addition, responses by family members and mental health providers need to be considered in future studies as added insights into the postpsychotic adjustment and may be helpful in clarifying participant perceptions and responses. However, the value of self-reports must never be diminished. Without input from the first-person lived experience, needed understanding of participant emotional, behavioral, interpersonal, and physiological responses to illness and treatment would not occur.

Because qualitative research is dependent on the researcher as the research instrument, attempts to bracket previous experience and expectations of the study may at times have been breached and participant responses may have been unconsciously directed. Hopefully, the use of an independent panel of judges and two member credibility

checks to critique personal and professional interpretations that may have influenced the study diminished the potential problem of bias. The ability to review the participant interviews and member credibility checks, as well as providing tables of the verbatim participant quotes, provided an audit trail of the data.

Despite these limitations, this study investigates a systematic process of adjusting to psychosis in a way that has not been previously reported. The proposed time frame of postpsychotic adjustment is replicable and needs to be evaluated in a larger sample within the same treatment setting as well as in other EPI programs around the globe to facilitate generation of testable hypotheses. The role of relapse in delaying the dynamic process of postpsychotic adjustment needs to be considered in future research. The economical ramifications of the four elements of postpsychotic adjustment need to be researched regarding implications for staff development in the initial treatment phases of early cognitive dissonance and attainment of insight. Collaboration with researchers studying cognitive function could yield more intricate explication of the phases of cognitive dissonance and insight. Identification of the financial and emotional costs of pushing patients prematurely into the phase of ordinariness when cognitive constancy has not been achieved needs to be studied.

Prerequisites to gaining a sense of self in the aftermath of a psychotic episode include the ability of the staff to engage the participant with social and therapeutic communication, demonstrate empathy, and provide encouragement. These factors contribute to the development of a positive attitude and a feeling of acceptance. Indicators of progress include the abilities to recognize that psychotic symptoms represent a disconnect from the reality of others, master the skill of conducting autonomous reality checks, initiate and maintain conversations with others, and complete age-appropriate activities of daily living. Results of this study validated the development of insight as the single most decisive factor in gaining the skill to move forward in the process of adjustment (Amador & Goldman, 1998).

CONCLUSION

The phenomenon of postpsychotic adjustment is a complex, dynamic, nonlinear process taking 3–5

years to potentially reach a level of readiness to fully engage in prepsychosis activities of daily living. The ability to separate the psychotic self from the ordinary self occurs by progressing through the postpsychotic adjustment process. This process begins with cognitive dissonance and culminates in ordinariness by attaining insight and establishing cognitive constancy. Engaging in therapeutic and social communication, experiencing empathy from others, finding the right medication, receiving encouragement, having a positive outlook, and verbalizing acceptance of illness are prerequisites to gaining a sense of self in the aftermath of a psychotic episode. Indicators of progress include the ability to recognize that psychotic symptoms represent a disconnect from the reality of others. The time frame and structural elements of each phase coupled with the identified cognitive, emotional, interpersonal, and physiological milestones can serve as a treatment map to present to the individual with schizophrenia and their family members. The phase-specific characteristics can serve as a guide for the development of treatment goals and objectives.

Today's emphasis on recovery from schizophrenia as an outcome instead of a process can place unrealistic expectations on the person to prematurely reengage with previous life activities. Not allowing the time required to complete the cognitive dissonance element can contribute to relapse and increase a sense of personal failure. The postpsychotic adjustment in schizophrenia reveals a highly intrapsychic and very personal cognitive process that extends far beyond attaining medication adherence, sustaining independent living, and maintaining employment.

REFERENCES

- Amador, X. F., & Goldman, J. M. (1998). Psychopathologic domains and insight in schizophrenia. *Psychiatric Clinics of North America*, *21*, 27–42.
- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders (Revised 4th ed.)*. Washington, DC: Author.
- Anderson, J., & Eppard, J. (1998). Van Kaam's method revisited. *Qualitative Health Research*, *8*, 399–403.
- Archie, S., Wilson, J. H., Woodward, K., Hobbs, H., Osborne, S., & McNiven, J. (2005). Psychotic disorders clinic and first-episode psychosis: A program evaluation. *Canadian Journal of Psychiatry*, *50*, 46–51.
- Birchwood, M., Todd, P., & Jackson, C. (1998). Early intervention in psychosis: The critical period hypothesis. *British Journal of Psychiatry*, *172*(Supplement 33), 53–59.
- Birmingham, L. (1999). Between prison and the community: The 'revolving door psychiatric patient' of the nineties. *British Journal of Psychiatry*, *174*, 378–379.
- Blanchard, J. J., Sayers, S. L., Collins, L. M. N., & Bellack, A. S. (2004). Affectivity in the problem-solving interactions of schizophrenia patients and their family members. *Schizophrenia Research*, *69*, 105–117.
- Boschi, S., Adams, R. E., Bromet, E. J., Lavelle, J. E., Everett, E., & Galambos, N. (2000). Coping with psychotic symptoms in the early phases of schizophrenia. *American Journal of Orthopsychiatry*, *70*, 242–252.
- Brady, N. (2005). A portrait of families with a member labeled schizophrenic. *Poster presented at the 19th Annual Meeting of the American Psychiatric Nurses Association, Nashville, TN.*
- Brown, S., Inskip, H., & Barraclough, B. (2000). Causes of the excess mortality of schizophrenia. *British Journal of Psychiatry*, *177*, 212–217.
- Champlin, B. E. (2009). Being there for another with a serious mental illness. *Qualitative Health Journal*, *19*, 1525–1535.
- Chafetz, L. (1996). The experience of severe mental illness: A life history approach. *Archives of Psychiatric Nursing*, *10*, 24–31.
- Clinton, M., Lunney, P., Edwards, H., Weir, D., & Barr, J. (1998). Perceived social support and community adaptation in schizophrenia. *Journal of Advanced Nursing*, *27*, 955–965.
- Cook, J. A., Blyler, C. R., Leff, H. S., McFarlane, W. R., Goldberg, R. W., Gold, P. B., Mueser, K. T., Shafer, M. S., Onken, S. J., Donegan, K., Carey, M. A., Kaufmann, C., & Razzano, L. A. (2008). The employment intervention demonstration program: Major findings and policy implications. *Psychiatric Rehabilitation Journal*, *31*, 291–295.
- Davidson, L. (2003). *Living outside mental illness*. New York: New York University Press.
- Deegan, P. E. (1990). Spirit breaking: When the helping professions hurt. *Human Psychology*, *18*, 301–313.
- Festinger, L. (1957). *A theory of cognitive dissonance*. Evanston, IL: Stanford University Press.
- Forchuk, C., Jewell, J., Tweedell, D., & Steinnagel, L. (2003). Reconnecting: The client experience of recovery from psychosis. *Perspectives in Psychiatric Care*, *39*, 141–150.
- Frese, F. J. (1998). The challenge of consumerism for schizophrenia. *Psychiatric Clinics of North America*, *21*, 233–249.
- Gastal, F., Andreoli, S., Quintana, M., Gameiro, M., Leite, S., & McGrath, J. (2000). Predicting the revolving door phenomenon among patients with schizophrenic, affective disorders and non-organic psychoses. *Revista De Saude Publica*, *34*, 280–285.
- Hoffmann, H., Kupper, Z., & Kunz, B. (2000). Hopelessness and its impact on rehabilitation outcome in schizophrenia—An exploratory study. *Schizophrenia Research*, *43*, 147–158.
- Khang, S. K., & Mowbray, C. T. (2005). Psychological traits and behavioral coping of psychiatric consumers: The mediating role of self-esteem. *Health and Social Work*, *30*, 87–97.
- Kravetz, S., Faust, M., & David, M. (2000). Accepting the mental illness label, perceived control over the illness,

- and quality of life. *Psychiatric Rehabilitation Journal*, 23, 323–332.
- Leavey, J. (2005). Youth experiences of living with mental health problems: Emergence, loss, adaptation and recovery (ELAR). *Canadian Journal of Community Mental Health*, 24, 109–126.
- Livneh, H., & Wilson, L. (2003). Coping strategies as predictors and mediators of disability-related variables and psychosocial adaptation: An exploratory investigation. *Rehabilitation Counseling Bulletin*, 46, 194–208.
- Lunt, A. (2002). A theory of recovery. *Journal of Psychosocial Nursing and Mental Health Services*, 40, 32–39.
- Microulis, D. (2004). The experience of psychosis as a traumatic event: Post psychotic adjustment state. Unpublished Master's Thesis, Intercollegiate College of Nursing, Washington State University, Spokane.
- Mishel, M. H. (1988). Uncertainty in illness. *Image: The Journal of Nursing Scholarship*, 20, 225–232.
- Moller, M., & Murphy, M. F. (1997). The three R's rehabilitation program: A prevention approach for the management of relapse symptoms associated with psychiatric diagnoses. *Psychiatric Rehabilitation Journal*, 20, 42–48.
- Polit, D. F., & Beck, C. T. (2006). *Essentials of nursing research, methods, appraisal, and utilization*. (6th ed.). New York: Lippincott Williams & Wilkins.
- Ponizovsky, A., Grinshpoon, A., Sasson, R., & Levav, I. (2004). Stress in adult students with schizophrenia in a supported education program. *Comprehensive Psychiatry*, 45, 401–407.
- Rabinowitz, J., Mark, M., Popper, M., Slyuzberg, M., & Munitz, H. (1995). Predicting revolving-door patients in a 9-year national sample. *Social Psychiatry and Psychiatric Epidemiology*, 30, 65–72.
- Randal, P., Simpson, A. I., & Laidlaw, T. (2003). Can recovery-focused multimodal psychotherapy facilitate symptom and function improvement in people with treatment-resistant psychotic illness? A comparison study. *Australia and New Zealand Journal of Psychiatry*, 37, 720–727.
- Salemo, E. M. (2002). Hope, power, and perception of self in individuals recovering from schizophrenia. *Visions: Journal of Rogerian Nursing Science*, 10, 23–36.
- Schiller, L. (1994). *The quiet room: A journey out of the torment of madness*. New York: Warner Books, Inc.
- Sells, D. J., Stayner, D. A., & Davidson, L. (2004). Recovering the self in schizophrenia: An integrative review of qualitative studies. *Psychiatric Quarterly*, 75, 87–97.
- Stanghellini, G., & Ballerini, M. (2007). Values in persons with schizophrenia. *Schizophrenia Bulletin*, 33, 131–141.
- Tandon, R., Keshavan, M., & Nasrallah, H. (2008). Schizophrenia, just the facts: What we know in 2008 Part I: Overview. *Schizophrenia Research*, 100, 4–19.
- Torrey, E. F. (2006). *Surviving schizophrenia: A manual for consumers, family members, and providers*. (4th ed.). New York: Harper Collins Publishers.
- Torrey, E. F. (1995). Jails and prisons: America's new mental hospitals. *American Journal of Public Health*, 85, 1611–1613.
- Vallenga, B. A., & Christenson, J. (1994). Persistent and severely mentally ill clients' perceptions of their mental illness. *Issues in Mental Health Nursing*, 15, 359–371.
- van Kaam, A. (1987). *Scientific formation. Formative spirituality*, Vol. 4. New York: Crossroad Publishing.
- Verdou, H., Husky, M., Tournier, M., Sorbara, F., & Swendsen, J. (2003). Social environments and daily life occurrence of psychotic symptoms—An experience sampling test in a non-clinical population. *Social Psychiatry and Psychiatric Epidemiology*, 38, 654–661.
- Walton, J. A. (2000). Schizophrenia and life in the world of others. *Canadian Journal of Nursing Research*, 32, 69–84.
- Weiden, P., & Havens, L. (1994). Psychotherapeutic management techniques in the treatment of outpatients with schizophrenia. *Hospital and Community Psychiatry*, 45, 549–555.
- Weiden, P., & Olfson, M. (1995). Cost of relapse in schizophrenia. *Schizophrenia Bulletin*, 21, 419–429.
- Wilson, J. E. H., Hobbs, H., & Archie, S. (2005). The right stuff for early intervention in psychosis: Time, attitude, place, intensity, treatment, and cost. *Journal of Psychosocial Nursing and Mental Health Services*, 43, 22–28.
- Worchester, S., & Moller, M. D. (2003). Postpsychotic adjustment might be part of psychosis. *Clinical Psychiatry News*, 31 (10), 28.