Early Intervention in Psychiatry 2015; **9:** 211–220 doi:10.1111/eip.12103

Original Article

Understanding the trauma of first-episode psychosis

Jane E. Dunkley, Glen W. Bates and Bruce M. Findlay

Abstract

Aim: This study examined the distress of first-episode psychosis (FEP) beyond the acute episode. It focused on how people understand the experience of FEP and its negative impact and how this relates to the traumagenic phenomena.

Methods: This research was a longitudinal qualitative study including interpretative phenomenological analysis of interview data. Ten people who had experienced FEP were interviewed 3–6 months following their psychotic episode (time one) and again 3 months after their initial interview (time two). Clinicians and significant others were interviewed at time two.

Results: Interpretative phenomenological analysis of the interview data supported a conceptualization of recovery from FEP within a broad trauma framework. The traumatic nature of FEP was found to be extended beyond the acute episode and was not linked to symptoms of post-traumatic stress disorder (PTSD) but included impact on identity, relationships and worldview.

Conclusions: The diagnosis of PTSD does not appear to capture all aspects of the distress of FEP. Traumagenic distress appears explained by incorporating a range of negative emotions, viewing the impact of FEP as ongoing rather than contained to the acute episode, and recognizes disruption of the individual's views of the self, others and the world.

Faculty of Life and Social Sciences, Swinburne University of Technology, Hawthorn, Victoria, Australia

Corresponding author: Dr Jane E. Dunkley, Orygen Youth Health, Locked Bag 10, Parkville, Vic. 3052, Australia. Email: jane.dunkley@mh.org.au

Received 25 January 2013; accepted 22 September 2013

Key words: first-episode psychosis, interpretative phenomenological analysis, longitudinal, trauma.

INTRODUCTION

First-episode psychosis (FEP) is defined as the first treated episode experienced by an individual in their lifetime.[1] As such, FEP is a psychiatric crisis which produces psychological disruption well beyond the active period of psychosis.[2,3] Management of the potential traumatic effects of psychiatric symptoms and the first experience of acute intervention is, therefore, especially important in treatment outcome.[4]

In some research, it has been established that the disruptive experience of FEP can be severe enough to precipitate post-traumatic stress disorder (PTSD).[5–10] Rates of trauma symptoms within the first 18 months following FEP range between 35% and 66%.[3,8,9,11,12] However, the relationship between PTSD and psychosis appears complex and uncertain.[13,14] Studies examining the traumatic impact of acute treatment and psychotic symptoms yield inconsistent results.[3,7,8,15,16] A phenomenologically pure diagnosis of PTSD is rare[8] because it is difficult to identify PTSD as a result of psychosis using the full diagnostic criteria.[3] Exploration of methodological issues and the role of participant characteristics has not provided clarification of these issues.[3,17] Further, concentrating on positive symptoms and acute treatment experiences as precipitants of PTSD ignores the other disruptive effects of trauma responses and the range of responses than can be exhibited.[3,8] It is therefore questionable whether a focus on the diagnostic criteria of PTSD is the most useful approach in understanding the traumatic impact associated with FEP.

The question of whether the experience of psychosis can precipitate PTSD fits within a broader debate about the nature of the diagnostic category.[13,18] To fulfil the DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision) criteria for PTSD,[19] an identifiable and objective stressor needs to be defined regardless of the potential trauma symptoms present.[20] DSM-IV-TR Criterion A_1 states that 'the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others' (pp. 427–428).[19] Recently, it has been argued that Criterion A_1 is too narrow and this is mirrored in the literature on the trauma of FEP. For instance, Criterion A_1 fails to acknowledge perceived or real threat to psychological integrity in addition to perceived threat to physical integrity,[8,13,21] even though the importance of the subjective experience has been demonstrated.[5,22] Yet, a prospective study on the relationship between appraisals of threat from psychotic symptoms and beliefs and subsequent PTSD among FEP participants found that only a minority experienced PTSD. The authors argued it was difficult to determine whether or not psychotic symptoms were indeed traumatic or superseded by other more distressing aspects of the experience. They also suggested that it might be time to assess appraisals during the immediate aftermath of psychosis. This they identified as 3–6 months following the episode and referred to as the psychological adjustment phase. It is after this period of time that the person is likely to have gained insight.[13]

Focusing on PTSD criteria to explain the traumagenic distress of FEP means that the range of responses following this experience remains poorly understood.[3,23] Criterion A_2 in the DSM-IV-TR states that the person's response to the trauma must include 'intense fear, helplessness, or horror' (pp. 427–428) as well as persistent avoidance of trauma-related stimuli, hyperarousal and re-experiencing of the event.[19] Yet, individuals report numerous trauma responses and not always these emotions[24,25] and different traumas produce different emotional responses.[24,26] The trauma of FEP can produce numerous psychological reactions beyond what would typically be classified as trauma symptomatology. For instance, following psychosis, studies have identified trauma responses such suicidal ideation,[3] loss, and entrapment, humiliation, defeat, hopelessness and anxiety.[27]

Understanding the full range of negative emotions is central to the conceptualization of adjustment and adaptation to FEP.[27] FEP typically occurs when the individual is developing a sense of self and identity, forming relationships with others and orienting themselves to the world.[2,28] Because of this, the traumatic nature of FEP can shatter one's beliefs about the self, others and the world[2] and have a profound effect on the individual in the short and long term.[3] Research has shown that future aspirations and social acceptance can be negatively impacted[3,29,30] and self-disintegration has been associated with the trauma of psychosis.[31] Further, unresolved psychotic symptoms and distressing treatment experiences can still occur. However, PTSD is a diagnosis that occurs after a traumatic event and views the traumatic experience as discrete.[18] Therefore, over-focusing on a diagnosis of PTSD is problematic because the impact of the ongoing distress is ignored.

The current study was part of a broader investigation aimed at developing a comprehensive understanding of the trauma of FEP and subsequent recovery and adaptation outcomes and processes. The aim of this study was to explore how people understand the experience of FEP and its negative impact. An in-depth phenomenological approach of interpretative phenomenological analysis (IPA) was adopted. IPA is directed at understanding the meaningful experience of individuals, as well as incorporating an interpretative component, which contextualizes and makes sense of the participant's experiences from a psychological perspective.[32–34] IPA focuses upon the person in context and how the individual understands and makes sense of the phenomena being examined (FEP) with regard to their relatedness to and engagement with it. IPA does not simply describe its results in terms of subjectivity, but recognizes that conclusions can also be made about the objective reality or the phenomena being studied.[34] IPA acknowledges that understanding people's experiences is done via the researcher's engagement with and interpretation of participants' accounts.[35,36] This analysis is informed by distinct theoretical constructs and directed towards answering predetermined research questions.[34] The researcher's interpretation is seen as necessary in forming an understanding of the participants' experiences.[36] This approach permitted a broad understanding of the trauma response not restricted to PTSD. This study was longitudinal and FEP participants were seen 3–6 months after their acute episode (time one) and 3–4 months after the first interview (time two). Interviews with significant others and clinicians were also conducted for the purpose of triangulation.

METHOD

Participant characteristics

Seven men and three women, aged between 22 and 28, who had experienced FEP 3–6 months earlier were recruited from the Alfred Psychiatric Outpatient Services ($n = 2$) and Orygen Youth Health ($n = 8$), Melbourne, Australia. Eight significant others over 18 years old also participated in this research: four mothers, two long-term girlfriends, one father and a previous long-term boyfriend. Two participants did not have a significant other who could be interviewed. One family member was non-English speaking and the second individual declined to participate due to work commitments. Ten clinicians who knew participants well were interviewed for the purpose of triangulation. Nine clinicians were case managers who had a background in psychology, psychiatric nursing, occupational therapy or social work. One psychiatrist was interviewed.

Table 1 shows the type of acute intervention participants received during their first-episode of psychosis. Most participants were seen by a crisis assessment team and had an inpatient admission. Three participants were hospitalized as involuntary clients and one participant was initially voluntary but later made involuntary during her admission. With regard to outpatient treatment, only one participant was on a Community Treatment Order.

Data on participants' history of trauma and other potentially significant life experiences are presented in Table 2.

Six FEP participants had experienced a trauma consistent with Criterion A, whereas nine had experienced other highly stressful events. Two participants did not have a history of trauma or significant life experiences and four participants had experienced multiple events. When assessed using the Mini-International Neuropsychiatric Interview (M.I.N.I.), five participants said they had experienced or witnessed a traumatic event as defined by Criterion A of the *DSM-IV-TR*.[19] However, these Criterion A events were not named by participants and of these five participants only one person fulfilled a diagnosis of PTSD. Therefore, it is unknown whether the events reported in the M.I.N.I. assessment relate to the Criterion A events reported in Table 2.

Diagnoses were confirmed by examination of medical files and the administration of the M.I.N.I. The M.I.N.I. is a short structured diagnostic interview for the DSM-IV[37] and The International Classification of Diseases.[38] The M.I.N.I. has excellent interrater reliability and corresponds well to the standard instrument Composite International Diagnostic Interview for the ICD-10 and the Structured Clinical Interview (SCID-P) for the DSM-III-R.[39] The DSM-IV version was used in the current study.[40]

Table 3 shows the participants' psychotic diagnoses overtime. All had experienced FEP in their lifetime. The M.I.N.I. revealed that four participants

TABLE 1. Acute treatment experience by FEP participants

Acute treatment	*n*
Police involvement during acute treatment	1
Hospital only	1
Crisis assessment team only	3
Hospital and crisis assessment team	5
Nil acute treatment and managed by the community treatment team	1

Note. $n = 10$, the total number of acute treatment experiences is 11 because one participant experienced police involvement as well as another form of intervention.
FEP, first-episode psychosis.

TABLE 2. Trauma history and significant life experiences

Experiences	*n*
Criterion A trauma	
Physical assault	1
Childhood sexual abuse	1
Witnessed violence	1
Death of a friend (occurred during the study)	1
Death of a family member	2
Other significant life events	
Bullied during school	4
Parents' separation	2
Family members with a mental illness	2
Birth complications	1

TABLE 3. Psychosis diagnoses of the sample

Psychotic disorder	Prior history *n*	Acute episode *n*	Time one *n*	Time two *n*
Psychotic symptoms	1	–	–	–
First-episode psychosis	–	3	2	1
Schizophreniform psychosis	–	5	6	6
Schizoaffective disorder	–	1	1	1
Major depressive disorder with psychotic features	–	3	0	1
Drug-induced psychosis	–	0	1	1

Note. $n = 10$, the total number of diagnoses during the acute episode is 12 because two individuals psychotic diagnoses changed during their acute phase.

had a current psychotic disorder at time one. Two participants' psychotic diagnoses changed during their acute phase.

The Positive and Negative Syndrome Scale (PANSS) was administered to measure the severity and quality of symptoms. PANSS ratings are based on information pertaining to the previous week and the measure is suitable for longitudinal assessment.[41] PANSS items include 18 adapted items from the Brief Psychiatric Rating Scale[41,42] and 12 adapted items from the Psychopathology Rating Scale.[41,43] The clinical implications of the PANSS scores and cut-off scores were determined by a previous study investigating the measure.[44] These scores are presented in Table 4. Information used to rate the PANSS items came from the interview itself, file notes and discussions with clinical staff.

The mean scores derived from the PANSS ratings at times one and two decreased over time (see Table 5). At times one and two, the average score on the negative scale was slightly higher than on the positive scale. According to the mean total score, FEP participants were mildly unwell at times one and two.

Procedure

Ethics approval was obtained from the research and ethics committees at the Alfred Hospital, Melbourne Health, and Swinburne University of Technology. All clients who had experienced FEP and were considered able to reflect on their experiences and provide informed consent were eligible for the study. They were contacted about the study via their treating clinician. FEP participants and significant others provided informed consent. FEP participants were interviewed 3–6 months after their acute episode (time one) to ensure some resolution of the episode, and again 3–4 months after the first interview (time two). Three to six months after the acute episode is also considered early recovery[45] and a period of adjustment and greater understanding.[13] Significant others and clinicians were interviewed at time two and on average 7 days after FEP participants' interviews. Demographics and information about participants' mental health issues were collected from files at times one and two. At time one, FEP participants partook in the M.I.N.I. and PANSS assessments and one semi-structured interview. At time two, the PANSS was re-administered along with a second semi-structured interview. Interrater reliability was obtained on 50% of the clinical assessments. Agreement was over 90% and the few instances of disagreement were resolved by discussion.

The semi-structured interview was designed to be open ended and adaptable and included prompts to invite the interviewee to engage in a narrative about their experiences of being unwell. FEP participants' interview schedules were based on an earlier pilot study[46] developed in consultation with a clinical psychologist and a psychiatrist at the Alfred Psychiatry Research Centre. Interviews with FEP participants and significant others ranged from 45 min to around 3 h.

The interview schedule had two parts: (i) understanding the experience of FEP and treatment; and (ii) the ongoing impact of the psychotic episode. Participants were asked to consider positive and negative and helpful and unhelpful changes. Interviews with significant others mirrored the FEP participants' interview protocols for triangulation.

TABLE 4. Range of scores associated with symptomatic status

Not unwell	Borderline unwell	Mildly unwell	Moderately unwell	Markedly unwell	Severely unwell
Under 33	34–57	58–74	75–94	95–115	116 and over

TABLE 5. Scores on the PANSS

	Time one			Time two		
	M	*SD*	Range	*M*	*SD*	Range
Total score	66.70	5.66	59–76	61.90	7.03	54–72
Positive scale	15.00	4.06	11–23	14.10	4.43	9–23
Negative scale	17.10	4.63	11–24	16.10	5.67	9–25
General psychopathology scale	34.60	3.17	29–39	31.70	3.83	23–37

Positive and Negative Syndrome Scale.

Significant others commented on questions in relation to their loved ones. The short semi-structured interview developed for FEP participants' clinicians gained their perspective on their clients' experiences of FEP, treatment and any changes they may have observed.

IPA

IPA is flexible and is understood as a perspective from which to *approach* analysis rather than a distinct method. The first aim is to approach the data trying to understand the participant's world and describe what it is like, with a focus on a specific experience such as FEP. The objective is to produce a coherent, third-person, psychologically informed account, which aims to get as close to the participant's view as possible. Then a more overtly interpretative analysis is conducted, which positions the initial description in relation to a wider context. Critical and conceptual commentary on the participant's meaning making is provided here.[34]

Guided by the IPA approach, thematic analysis was conducted using verbatim transcripts in conjunction with the researcher's interpretation of the interviews. Each FEP participant's two interviews were read successively to get a sense of the individual's overall experiences. Interviews were analysed in groups (i.e. FEP participants, the significant others and the clinicians) to give a sense of each group's perspective prior to making comparisons across groups. This also allowed for the initial experience of FEP to be understood before obtaining other people's perspectives.

All interviews received repeated inspection. Initially, unfocused notes reflecting the investigator's initial thoughts and observations were produced. Keywords and sentences were then highlighted and grouped into three broad areas: negative aspects of FEP, positive features of FEP, and recovery processes and outcomes. Next, keywords and sentences within these three broad areas were clustered into collective theme categories.

The researcher looked at common and unique categories for each individual to cluster them as thematic units and identify anomalies. Connections between thematic units were made to establish themes. Rereading and reorganizing themes ensured that the clustering of thematic units made sense in relation to the original transcripts and all data were taken into account. Analysis was completed once all that was shared by the participants was captured in the themes. Definitions of themes were developed and translated into the researcher's words through careful examination of participants' quotes. The researcher also drew on theory and research on the trauma of psychosis[2,3,27,29–31] to develop theme definitions. Interviews with family members and clinicians were analysed to generate another dataset that gave insight into the FEP participants' experiences.

Reliability and validity

Coding of the interview data and theme definitions sought agreement between the investigator, second author and an independent examiner. Cross-coding provided an initial agreement rate of approximately 80%. Disagreements were resolved through discussion and clarification of themes. An independent audit of the transcribed data established the integrity of the research findings. The second interview with FEP participants acted as a confirmation of the person's experiences. Interviews with significant others and clinicians allowed for triangulation analysis to validate themes.

RESULTS

The experience of psychotic symptoms ranged from being deeply distressing to merely an annoyance. Central to the distress associated with the acute episode was the impact of FEP on the person's life, well-being, and view of self, the world and others.

During hospitalization, co-patients, staff and medication were found to contribute to distress, and distress associated with acute treatment was sometimes enmeshed with psychotic symptomatology. For instance, symptoms could cause suspiciousness and fear of staff and co-patients. Although it was less concerning for people treated in the home, interactions with staff and medication side effects could still be disturbing.

However, two participants viewed their symptoms as both a source of upset and of comfort and improvement, whereas one person reported that his symptom experiences were entirely positive. Further, some participants considered the benefits of treatment. Interestingly, the negative impact of FEP went beyond the acute episode to include ongoing consequences. Six key themes emerged that were related to the distress of the acute episode and the impact of the illness (see Table 6).

Perceived enforced treatment

This theme was defined as being subject to outside intrusive and impersonal discipline, enforced treatment, and monitoring. This could lead to feeling angry, fearful, unheard and disempowered:

TABLE 6. Themes relating to the distress associated with FEP

Themes	Subthemes
1. Perceived enforced treatment	–
2. Disintegration	–
3. Stigma	(a) Self-stigma (b) Stigma from others
4. Estrangement	–
5. Sense of loss and deficit	–
6. Recognizing the illness as an ongoing problem	–

FEP, first-episode psychosis.

> I'm my own person. You can't do this. . . . I was angry at the doctors for locking me up. . . . I'm not angry because I have a chemical imbalance. I'm angry because strangers who don't know me have locked me up and taken my freedom . . . I'd gotten locked up and had my freedom taken away for being me.

Disintegration

A perceived lack of control over one's self and one's interaction with others due to psychotic symptoms was clearly evident and central to distress during the acute phase of FEP. The person's sense of self appeared fragmented and could be associated with ambiguity, disbelief, uncontrollability, and feeling surreal and disconnected from one's identity, others and the world. One participant reported, 'I was doing things that I couldn't control. . . . when you're aware of something you're doing but you can't stop it, it burns you'.

> Everything looked different as well. Like people looked different. And I guess I was, like things sounded different as well. Like . . . I could hear a police siren . . . not a police siren an ambulance and it just sounded I don't know like not real, I don't know like imagine you were in a cartoon or something.

For some people, the experience of *disintegration* continued after the acute episode resolved.

> I'm feeling totally different like I'm not myself and that freaks me out . . . Like the thoughts that I'm thinking and the way that I talk to other people like sometimes it surprise me. . . . I have no idea what I just said and what was you know my face expression . . . freak me out and my thoughts start going why you know why, why is that.

Stigma

The theme stigma related to (i) *self-stigma* and (ii) stigma from others. Stigma could be associated with feeling degraded and embarrassed. Self-stigma was internally focused and involved negative self-labelling, having a destructive attitude towards mental illness and its treatment, and believing one is unappealing to others because of one's mental illness.

> I never used to think that I was crazy (laugh) until I actually had people coming around to the house everyday to make sure I wasn't dead (laugh) . . . Frightening to be honest, it's not fun. I hate to think that I'll end one day up in a padded cell with a straight jacket on not knowing my name, that's a bit scary.

Stigma from others was externally focused and associated with being discredited by people and society in general because of one's mental illness.

> Like people just don't understand at all and so, and people make judgements on your decisions . . . so I just don't discuss it with people like if anything I'll say it's depression . . . like on Law and Order the other day they said, someone said oh this person has psychosis and then the woman to me that means murder!. . . . And there's even this club that we were going to and it's called psychosis.

Estrangement

Although evident during the acute illness, estrangement was predominant in the recovery phase. It was associated with feelings that people did not understand or relate to the illness experience and were unable to provide support. This could be the person's perception or indicative of actual behaviour. Communicating about the illness was difficult, the person could feel different due to the illness, and treatment and/or symptoms could produce isolation and disconnection.

> Before I was unwell I needed twenty hands to count all my friends. After being unwell I can use two, like people fade away, people drift away, they can't, they don't either want to deal with it or they don't understand or when you try to talk to them they don't listen.

Sense of loss and deficit

This theme reflected a wide range of losses associated with different aspects of the participants' lives and identity. Losses and deficits were specific or general and were associated with different aspects of life or sense of self. The theme was present during the acute episode but was most evident in the recovery phase.

> It's changed me heaps cause now I'm a lot more timid. Not very outgoing. Very shy sort of person. Lost a lot of confidence. A lot of people have said I've changed physically as well because I've put on a lot of weight from the treatment.

Recognizing the illness as an ongoing problem

Mental health issues and/or secondary consequences were identified as an ongoing and enduring difficulty. The illness was viewed as a struggle which required ongoing management. Progress was regarded as slow and produced a sense of disempowerment and hopelessness.

> At the moment I have no control over anything. The voices have affected me so much. The depression's affected me so much and I just feel so powerless to change it. Cause everything's happening so slowly like being treated . . . I feel so powerless like I wish I could change it all in an instant.

Triangulation of the data

Significant others identified the experience of *disintegration* and *perceived enforced treatment* in relation to the acute episode. All themes relating to the impact of FEP were corroborated by significant others except *disintegration*. Clinicians did not confirm the theme *disintegration* or *perceived enforced treatment* in relation to the acute episode. Further, the themes *disintegration* and *stigma from others* were not identified when clinicians discussed the impact of FEP. Clinicians particularly focused on the theme *recognizing the illness as an ongoing problem*.

DISCUSSION

This study demonstrates that the traumagenic distress of FEP goes beyond the acute episode and the diagnostic criteria of PTSD. Criterion A_1 describes trauma as a discrete event or events and previous research examining the distress of FEP has adopted this perspective by examining PTSD as an outcome of the acute episode.[9,10,15] The current findings demonstrate, however, that the traumagenic distress of FEP is not confined to a short period but operates in the longer term, as most themes related to the aftermath of this experience. The distress associated with FEP was described as enduring and emerged in themes such as *recognizing the illness as an ongoing problem* and *sense of loss and deficit* and so FEP cannot therefore be understood as a discrete event. How the experience of FEP impacts on the individual's beliefs about, and experiences of, the self, others, and the world in the short and long term appears more relevant to the traumagenic distress associated with FEP rather than the episode itself. This is consistent with suggestions by other investigators that the low rate of PTSD in their study could indicate that other aspects of the experience may have been more intensely disruptive than psychotic symptoms.[13] Moreover, in this study, psychotic symptoms and acute treatment were not the main focus of distress for the majority of participants and most only provided descriptive accounts of these experiences.

Criterion A_1 also defines trauma as an identifiable and objective event and does not recognize threat to psychological integrity or perceived threat. Although studies examining the trauma of FEP have argued for the need to consider psychosis as a distressing internal experience, most research has objectified the acute episode by focusing on psychotic symptoms and treatment experiences as possible precipitators of PTSD rather than considering the subjective experience.[7,10,15] Only two key themes associated with the acute episode were identified via IPA: *disintegration* and *perceived enforced treatment*. Although the content of the theme *perceived enforced treatment* aligns with previous research demonstrating the distress of coercive treatment,[15] in this study, the source of the distress was perceived helplessness rather than the specific aspects of the intervention itself. Similarly, the distress associated with psychosis was not related to symptoms per se but to the self-disturbance and irregularities of the self caused by the psychotic symptoms. Rather than focusing on the objective features of FEP, the themes *perceived enforced treatment* and *disintegration* demonstrate that the trauma of the acute episode is subjective and internally focused. A hallmark of this distress is a sense of loss of control.

Although another study looked at appraisals of threat from psychotic symptoms, post-psychotic PTSD was still not a major finding.[13] Interestingly, in the current study, the emotional reactions expected following a trauma as defined by the PTSD diagnostic criteria were also not strongly evident. Helplessness was apparent in the themes *disintegration*, *perceived enforced treatment*, and *viewing the illness as an ongoing problem*, and feeling frightened was evident in the theme *perceived enforced treatment*. However, intense fear and horror, as described in Criterion A_2, was not described in response to the psychotic episode. Instead, a range of other negative emotional reactions to FEP were identified including perceived vulnerability, hopelessness, disempowerment, loneliness, disconnectedness, anger,

uncontrollability, disbelief, ambiguity, insecurity, unlikeability and shame. This is consistent with other research demonstrating that individuals can develop PTSD without intense fear, helplessness, and horror, and instead experience a range of other negative emotions such as worry, sadness, guilt, frustration and shame.[24,25] However, the classic PTSD symptoms of re-experiencing and hyperarousal described in criteria B and D were also not described by participants in the current study. The theme *estrangement* could reflect avoidance as described in Criterion C, yet numbness and avoidance of stimuli characteristic of PTSD did not emerge. As participants were interviewed 3–6 months following their acute episode, had PTSD been an outcome of the trauma of FEP it would have been clearly established by then.

Although post-psychotic PTSD cannot be ruled out in understanding responses to FEP, this research suggests that PTSD fails to capture all aspects of the distress of FEP. This may account for the low prevalence of a phenomenologically pure diagnosis of PTSD. Instead, a broader concept of the traumagenic distress of FEP warrants consideration, which includes a range of negative emotions and views the impact of FEP as ongoing rather than contained to the acute episode. A key finding of this research was the impact of FEP on how an individual views him or herself, others and the world as demonstrated by the themes such as *stigma* and *estrangement*. Disruption to the sense of self as a result of psychosis is a long-standing topic in psychiatric literature.[31,47–50] Further, themes such as *stigma* and *sense of loss and deficit* as well as reactions of hopelessness and shame have also been identified in previous studies.[3,27,30] However, this research extends these ideas by placing them within a trauma framework and identifying how they fit together in order to provide a comprehensive understanding of the distress associated with FEP. It is argued that these experiences and reactions are the hallmark of traumagenic distress associated with FEP and can characterize the traumagenic profile for this experience.

The broader understanding of traumagenic distress that emerged in this study has important implications for treatment. For instance, the themes identified by IPA suggest areas of potential focus in the provision of psychoeducation to significant others. Significant others identified nearly all of the themes in the FEP participants' interviews but did not recognize that the experience of disintegration could continue after the acute episode. It is possible that it was difficult for significant others to identify the theme *disintegration* during the recovery phase because it may not have been as explicit as it was during the acute episode. Furthermore, the experience of disintegration appears to be an internal experience which people who have experienced FEP may find difficult to articulate. It could be beneficial to talk to significant others about the enduring impact of FEP on the self.

This study also points to the sources of trauma and the range of negative emotional responses clinicians could focus on in treatment. Clinicians' responses did not significantly vary according to their professional background. The only theme endorsed by clinicians was *viewing the illness as an ongoing problem*. Clinicians were inclined to raise issues such as diagnostic dilemmas, symptom presentations and ongoing functional impairment. This may reflect the dominant model of treatment, which is clinical recovery. Clinical recovery reflects a medical model of the illness and focuses on diagnosis, illness duration, the illness stage at which treatment began and the level of disability.[51] A failure to recognize the range of emotional responses following FEP and its impact on the individual's sense of self and relationships with others could have a range of clinical implications such as inadequately addressing the distress and negative impact of FEP, poor treatment adherence, and problematic adaptation and integration of FEP. This study points to other elements clinicians can focus on to improve their treatment. For example, taking a phenomenological, self-disorder approach[52] to treating people with FEP could reduce the impact and distress of disintegration. Other factors such as the impact on a client's relationships, their perceived vulnerability and fear of relapse, feelings of hopelessness, and lack of control are likely to be important foci in treatment. Findings could also enhance current treatment practices such as cognitively orientated psychotherapy (COPE) for early psychosis developed at Orygen Youth Health, Melbourne, Australia. COPE focuses on the client's appraisals of themselves and their illness and how their sense of self has been distorted by the psychotic episode.[53]

In conclusion, this study demonstrates the importance of refocusing attention on understanding the impact of FEP from a broader perspective. The themes identified in this study included *disintegration*, *estrangement*, *stigma*, *sense of loss and deficit*, *recognizing the illness as an ongoing problem*, and *perceived enforced treatment*. These themes point to the impact of FEP on the person's identity, relationships and the range of negative emotional responses that can occur. Future research could examine how aspects of this trauma profile influence and relate to adjustment and adaptation to FEP, including the

possibility of constructive change. The clinical utility of targeting some of these aspects of the trauma response could also be investigated. The 10 FEP participants in this study were from a range of backgrounds and thus the themes are likely to be relevant to other people with FEP. However, further research with different cohorts of people with FEP is needed to establish a broader representation of the themes. A large-scale quantitative study could also assist in ascertaining how representative these themes are among FEP clients.

ACKNOWLEDGEMENTS

We would like to thank the Alfred Psychiatry Research Centre, especially Professor Paul Fitzgerald and Margaret Foulds, and ORYGEN Youth Health Research Centre, particularly Dr Ruth Parslow and the SHARP research team. We are also grateful to Associate Professor Amanda Richdale, Felicity Butselaar, and the individuals and clinicians who participated in this research.

REFERENCES

1. National Early Psychosis Project Clinical Guidelines Working Party. Australian Clinical Guidelines for Early Psychosis. Melbourne: National Early Psychosis Project, University of Melbourne, 1998.
2. Riedesser P. Psychosis as a traumatic event. In: Burgin D, Meng H, eds. *Childhood and Adolescent Psychosis*. Basel: Karger, 2004; 61–6.
3. Tarrier N, Khan S, Cater J, Picken A. The subjective consequences of suffering a first episode psychosis: trauma and suicide behaviour. *Soc Psychiatry Psychiatr Epidemiol* 2007; **42**: 29–35.
4. Mueser KT, Rosenberg SD. Treating the trauma of first-episode psychosis: a PTSD perspective. *J Ment Health* 2003; **12**: 103–8.
5. Brunet K, Birchwood M. *PTSD following recovery from first-episode psychosis: the threat from persecutors, voices, and 'being mad'*. Paper presented at: The Meeting of the Sixth International Conference on Early Psychosis; 20–22 Oct 2008, Melbourne, Australia. 2008.
6. Beattie N, Shannon C, Kavanagh M, Mulholland C. Predictors of PTSD symptoms in response to psychosis and psychiatric admission. *J Nerv Ment Dis* 2009; **197**: 56–60.
7. Centofanti AT, Smith DI, Altieri T. Posttraumatic stress disorder as a reaction to the experience of psychosis and its sequelae. *Clin Psychol* 2005; **9**: 15–23.
8. Jackson C, Knott C, Skeate A, Birchwood M. The trauma of first episode psychosis: the role of cognitive mediation. *Aust N Z J Psychiatry* 2004; **38**: 327–33.
9. McGorry PD, Chanen A, McCarthy E, Van Reil R, McKenzie D, Singh BS. Posttraumatic stress disorder following recent-onset psychosis. *J Nerv Ment Dis* 1991; **179**: 253–8.
10. Shaw K, McFarlane AC, Bookless C, Air T. The aetiology of post-psychotic posttraumatic stress disorder following a psychotic episode. *J Trauma Stress* 2002; **15**: 39–47.
11. Bendall S, Alvarez-Jimenez M, Hulbert CA, McGorry PD, Jackson HJ. Childhood trauma increases the risk of post-traumatic stress disorder in response to first-episode psychosis. *Aust N Z J Psychiatry* 2012; **46**: 35–9.
12. Meuser KT, Lu W, Rosenberg SD, Wolfe R. The trauma of psychosis: posttraumatic stress disorder and recent onset psychosis. *Schizophr Res* 2010; **116**: 217–27.
13. Brunet K, Birchwood M, Upthegrove R, Michail M, Ross K. A prospective study of PTSD following recovery from first-episode psychosis: the threat from persecutors, voices, and patienthood. *Br J Clin Psychol* 2012; **51**: 418–33.
14. Morrison AP, Frame L, Larkin W. Relationships between trauma and psychosis: a review and integration. *Br J Clin Psychol* 2003; **42**: 331–53.
15. Meyer H, Taiminen T, Vuori T, Aijala A, Helenius H. Posttraumtic stress disorder symptoms related to psychosis and acute involuntary hospitalization in schizophrenic and delusional patients. *J Nerv Ment Dis* 1999; **187**: 343–52.
16. Shaw K, McFarlane AC, Bookless C. The phenomenology of traumatic reactions to psychotic illness. *J Nerv Ment Dis* 1997; **185**: 434–41.
17. Chisholm B, Freeman D, Cooke A. Identifying potential predictors of traumatic reactions to psychotic episodes. *Br J Clin Psychol* 2006; **45**: 545–59.
18. Bendall S, McGorry P, Krstev H. The trauma of being psychotic. In: Larkin W, Morrison AP, eds. *Trauma and Psychosis: New Directions for Theory and Therapy*. London: Routledge, 2006; 58–74.
19. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*, 4th edn, text revision. Washington, DC: Author, 2000.
20. Breslau N, Chase GA, Anthony JC. The uniqueness of the DSM definition of post-traumatic stress disorder: implications for research [Editorial]. *Psychol Med* 2002; **32**: 573–6.
21. Christopher M. A broader view of trauma: a biopsychosocial-evolutionary view of the role of the traumatic stress response in the emergence of pathology and/or growth. *Clin Psychol Rev* 2004; **24**: 75–98.
22. Ehlers A, Clark DM. A cognitive model of posttraumatic stress disorder. *Behav Res Ther* 2000; **38**: 319–45.
23. Fowler D. Psychological formulation of early episodes of psychosis: a cognitive model. In: Birchwood M, Fowler D, Jackson C, eds. *Early Intervention in Psychosis: A Guide to Concepts, Evidence and Interventions*. Chichester: John Wiley & Sons, 2000; 101–27.
24. Walter M, Bates G. Posttraumatic growth and recovery from posttraumatic stress disorder. In: Olisah V, ed. *Essential Notes in Psychiatry*. Croatia: Intech, 2012; 143–86.
25. O'Donnell ML, Creamer M, McFarlane AC, Silove D, Bryant RA. Should A2 be a diagnostic requirement for posttraumatic stress disorder in DSM-V? *Psychiatry Res* 2010; **176**: 257–60.
26. Amstadter AB, Vernon LL. Emotional reactions during and after trauma: a comparison of trauma types. *J Aggress Maltreat Trauma* 2008; **16**: 391–408.
27. Jackson C, Iqbal Z. Psychological adjustment to early psychosis. In: Birchwood M, Fowler D, Jackson C, eds. *Early Intervention in Psychosis: A Guide to Concepts, Evidence and Interventions*. Chichester: John Wiley & Sons, 2000; 64–100.
28. McGorry PD, Yung A. Early intervention in psychosis: an overdue reform. *Aust N Z J Psychiatry* 2003; **37**: 393–8.
29. Gumley AI, MacBeth A. A trauma-based model of relapse in psychosis. In: Larkin W, Morrison AT, eds. *Trauma and Psychosis: New Directions for Theory and Therapy*. London: Routledge, 2006; 283–304.
30. MacDonald E, Sauer K, Howie L, Albiston D. What happens to social relationships in early psychosis? A phenomenological study of young people's experiences. *J Ment Health* 2005; **14**: 129–43.

31. Williams-Keeler L, Milliken H, Jones B. Psychosis as a precipitating trauma for PTSD: a treatment strategy. *Am J Orthopsychiatry* 1994; **64**: 493–8.
32. Biggerstaff D, Thompson A. Interpretative phenomenological analysis (IPA): a qualitative methodology of choice in healthcare research. *Qual Res Psychol* 2008; **5**: 214–24.
33. Perry BM, Taylor D, Shaw SK. 'You've got to have a positive state of mind': an interpretative phenomenological analysis of hope and first episode psychosis. *J Ment Health* 2007; **16**: 781–93.
34. Larkin M, Watts S, Clifton E. Giving voice and making sense in interpretative phenomenological analysis. *Qual Res Psychol* 2006; **3**: 102–20.
35. Smith JA, Osborn M. Interpretative phenomenological analysis. In: Breakwell GM, ed. *Doing Social Psychology Research*. Chichester: Wiley-Blackwell, 2007; 229–53.
36. Willig C. *Introducing Qualitative Research in Psychology: Adventures in Theory and Method*. Buckingham: Open University Press, 2001.
37. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, 4th edn. Washington, DC: Author, 1994.
38. World Health Organization. *The International Classification of Diseases (ICD-10)*, 10th edn. Geneva: Author, 1992.
39. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)*, 3rd edn. revision. Washington, DC: Author, 1987.
40. Sheehan DV, Lecrubier Y, Harnett-Sheehan K *et al*. The Mini-International Neuropsychiatric Interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for the DSM-IV and ICD-10. *J Clin Psychiatry* 1998; **59** (Suppl. 20): 22–32.
41. Kay SR, Fiszbein A, Opler LA. The Positive and Negative Syndrome Scale (PANSS) for schizophrenia. *Schizophr Bull* 1987; **13**: 261–76.
42. Overall JE, Gorham DR. Brief Psychiatric Rating scale. *Psychol Rep* 1962; **10**: 799–812.
43. Singh MM, Kay SRA. A comparative study of haloperidol and chlorpromazine in terms of clinical effects and therapeutic reversal with benztropine in schizophrenia: the theoretical implications for potency differences among neuroleptics. *Psychopharmacologia* 1975; **43**: 103–13.
44. Leucht S, Kane JM, Kissling W, Hamann J, Etschel E, Engel RR. What does the PANSS mean? *Schizophr Res* 2005; **79**: 231–8.
45. Early Psychosis Guidelines Writing Group. *The Australian Clinical Guidelines for Early Psychosis*, 2nd edn. Melbourne: Orygen Youth Health, 2010.
46. Dunkley JE, Bates GW, Foulds M, Fitzgerald P. Understanding adaptation to first-episode psychosis: the relevance of trauma and posttraumatic growth. *Australas J Disaster Trauma Stud* 2007; **1** [Cited 3 Jul 2007.] Available from URL: http://www.massey.ac.nz/~trauma/issues/2007-1/dunkley.htm
47. Cermolacce M, Naudin J, Parnas J. The 'minimal self' in psychopathology: re-examining the self-disorders in the schizophrenia spectrum. *Conscious Cogn* 2007; **16**: 703–14.
48. Jaspers K. *General Psychopathology* (Hoenig J, Hamilton MW, Trans.). Manchester: Manchester University Press, (Original work published 1923), 1963.
49. Laing RD. *The Divided Self: An Existential Study in Sanity and Madness*. Harmondsworth: Penguin Books, 1965.
50. Lysaker PH, Lysaker JT. Psychosis and the disintegration of dialogical self-structure: problems posed by schizophrenia for the maintenance of dialogue. *Br J Med Psychol* 2001; **74**: 23–33.
51. Fitzpatrick C. A new word in serious mental illness: field begins to engage in debate with major implications for services. *Behav Healthc Tomorrow* 2002; **11**: 16–21.
52. Nelson B, Sass LA. Medusa's stare: a case study of working with self-disturbance in the early phase of schizophrenia. *Clin Case Stud* 2009; **8**: 489–504.
53. Jackson H, Edwards J, Hulbert C, McGorry P. Recovery from psychosis: psychological interventions. In: McGorry PM, Jackson HJ, eds. *The Recognition and Management of Early Psychosis: A Preventive Approach*. Cambridge: Cambridge University Press, 1999; 265–307.