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Author/s:

Tong, J;Simpson, K;Alvarez-Jimenez, M;Bendall, S

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Tong Janet (Orcid ID: 0000-0002-7023-4027)

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TALKING ABOUT TRAUMA IN THERAPY FOR FEP

**Talking about Trauma in Therapy: Perspectives from Young People with
Post-traumatic Stress Symptoms and First Episode Psychosis**

Janet Tong^a, Katrina Simpson^a, Mario Alvarez-Jimenez^{b,c}, Sarah Bendall^{b,c}

^a School of Psychological Sciences, Monash University, 18 Innovation Walk, Clayton Campus, Monash University, VIC, Australia

^b Orygen, The National Centre of Excellence in Youth Mental Health, 35 Poplar Road, Parkville, VIC, Australia

^c Centre for Youth Mental Health, The University of Melbourne, VIC, Australia

Correspondence to Sarah Bendall; Orygen, The National Centre of Excellence in Youth Mental Health, 35 Poplar Road, Parkville, VIC, Australia.

E-mail: sarah.bendall@orygen.org.au

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Abstract

Aim: Despite recommendations from national guidelines, individuals with first episode psychosis (FEP) are currently unlikely to have the effects of their traumatic experiences assessed and treated within psychosis treatment. This may be due to the mismatch between the objectives of trauma-specific treatments (directly targeting post-traumatic stress symptoms by talking about the trauma) and trauma-informed care (limiting practices that may retraumatise clients). We aimed to gain an understanding of what it was like for young people to talk about trauma in FEP treatment, and how their experiences related to the broad conceptualisations of trauma-informed and trauma-specific treatment approaches. **Methods:** Semi-structured interviews were conducted with eleven participants (18-27 years) with FEP and PTSD symptoms after the completion of an intervention for the effects of trauma. Transcripts were analysed using an interpretative phenomenological approach. **Results:** Two superordinate themes were identified, each with subordinate themes. 1. Reluctance to approach the trauma memory: 1a. Not wanting to talk about trauma; 1b. Difficulty acknowledging that the trauma had occurred; 1c. Not wanting to re-experience emotions associated with trauma. 2. Factors aiding the process: 2a. Desire for change; 2b. Not being pushed to talk; 2c. Valuing the case manager; 2d. Time. **Conclusions:** A majority of participants in the study experienced reluctance when recounting their trauma memories. Being in control of how trauma memories are shared and having time for the therapeutic

relationship to develop enhanced participants' readiness for talking about trauma.

Incorporating trauma-informed principles and motivational interviewing could aid in facilitating the processes around talking about trauma.

Keywords: Childhood Trauma; Cognitive Behavioural Therapy; First Episode Psychosis; Motivational Interviewing; Post-traumatic Stress Disorder

Childhood trauma is common in young people accessing early psychosis services, with over 65% reporting some form of abuse or neglect (Bendall, Alvarez-Jimenez, Hulbert, McGorry, & Jackson, 2012; Trauelsen et al., 2015). Meta-analytical research has found exposure to traumatic experiences during childhood increases the risk of developing psychosis by 2.72 times (Varese et al., 2012). The presence of a trauma history can affect the severity of positive symptoms, treatment trajectory and longer-term outcomes in the form of reduced treatment adherence, vulnerability to relapse and increased number of hospitalisations (Bailey et al., 2018; Doering et al., 1998; Rosenberg, Lu, Mueser, Jankowski, & Cournos, 2007). Therefore, it is important to develop effective treatment practices to address all the above factors, as well as specific therapies for PTSD in psychosis, which has been the focus of research to date (e.g., van den Berg et al., 2015).

Approximately one in two people experience PTSD symptoms and one in three experience diagnostic PTSD following a first psychotic episode (Rodrigues & Anderson, 2017).

National guidelines for schizophrenia and psychotic disorders state that clinicians should routinely and sensitively assess for exposure to adversity, and consider whether service practices have the potential to retraumatise clients (Galletly et al., 2016; NICE, 2014). The

trauma-informed care (TIC) framework has attempted to establish broad service structures that facilitate appropriate responses to trauma, including a focus on minimising practices that may retraumatise already traumatised individuals (SAMHSA, 2012). TIC differs from trauma-specific treatments in that the aim is not to treat symptoms related to trauma, but to provide an overarching framework that integrates trauma awareness into all aspects of service delivery to promote trauma-sensitive practices. These include fostering healing relationships, ensuring that power within therapy is shared, and valuing the client's choices and autonomy as specific processes to minimise client retraumatisation (MHCC, 2014).

To date in psychosis service delivery, trauma-informed care principles (SAMHSA, 2012) have been primarily directed at seclusion and restraint practices as they can be experienced as distressing, invasive or insensitive (Mueser, Lu, Rosenberg, & Wolfe, 2010), and have the potential to trigger both trauma-related and psychotic symptoms (Frueh et al., 2000; Sibitz et al., 2011). These practices have been shown to be more often applied to individuals with a diagnosis of schizophrenia and in those with a history of trauma (Beghi, Peroni, Gabola, Rossetti, & Cornaggia, 2013; Steinert, Schmid, & Bergbauer, 2006).

In outpatient and community mental health settings, treatments addressing the effects of trauma in those with psychosis have focused on trauma-specific approaches, which have been shown to be effective in reducing PTSD symptoms (Brand, McEnery, Rossell, Bendall, & Thomas, 2017; Swan, Keen, Reynolds, & Onwumere, 2017). These treatments have in common the main mechanism of targeting trauma memories to evoke and promote emotional processing (Schnyder et al., 2015). While shown to be unrelated to treatment outcome, participants have reported experiencing increases in emotional distress and temporary

exacerbation of PTSD and/or psychotic symptoms when receiving these treatments (Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002; Tong, Simpson, Alvarez-Jimenez, & Bendall, 2017).

Taken together, the disparity between the empirical evidence of PTSD treatment effectiveness and the experiential accounts from treatment completers reflects the tension between the objectives of trauma-specific treatments and TIC. The overarching aim of trauma-specific treatments is to directly target the psychological symptoms and sequelae of trauma by implementing effective treatments that may temporarily induce distress and symptom exacerbation, yet one of the essential features of TIC is to limit opportunity for retraumatisation (Fallot & Harris, 2009; Morris, 2015).

This contradiction may underlie FEP clinicians' concerns of increasing client distress and exacerbating psychotic symptoms, which have been found to affect their overall confidence in assessing and treating trauma. These concerns prevail even in clinicians who recognise trauma in their clients and operate under a 'trauma-centric' model of psychosis (Gairns, Alvarez-Jimenez, Hulbert, McGorry, & Bendall, 2015; Walters, Hogg, & Gillmore, 2016). These concerns may contribute to why trauma and its effects continue to be inconsistently assessed and treated in individuals with psychosis (Cunningham et al., 2016; Sampson & Read, 2017).

An important perspective to consider as interventions continue to evolve for the FEP group, and one that has been lacking thus far, is that of the service user. Qualitative enquiry into the experience of trauma treatment will give clinicians more information about the processes that make up treatment, to aid in the understanding of how we can accommodate

the (at times competing) objectives of trauma-specific treatment and TIC. We developed a service delivery model for addressing trauma in FEP services that is trauma-informed (e.g., promotes client choice and autonomy), includes guideline recommendations (e.g., assessment of trauma and its effects), and includes elements of trauma-specific treatments (e.g., talking about trauma). In the current study, a qualitative Interpretative Phenomenological Analysis (IPA) approach was employed utilising semi-structured interviews to explore the experiences of participants who completed the intervention to gain an understanding of what it was like to talk about trauma, and how their experiences related to the broad conceptualisations of trauma-informed and trauma-specific treatment approaches.

Method

Sample and context

Participants were recruited from a pilot trial of a trauma-informed and trauma-specific intervention for young people with FEP (Bendall, 2014). Inclusion criteria for the pilot trial are presented in Table 1. The trial took place at an early psychosis service within a publicly funded, intensive outpatient mental health service for young people aged 15-25. The trauma intervention was conducted as part of standard case management within an 18-month to two-year window of care (EPPIC, 2010). Researchers and clinicians collaborated to ensure the pragmatic needs of 'real-world' clinical practice were met, while treating trauma symptoms in individuals with early psychosis. Ethical approval was sought and granted from the relevant ethics committees.

Insert Table 1 about here.

In brief, the trauma intervention comprised four modules (for full descriptions, please see Bendall, Alvarez-Jimenez, Killackey, & Jackson, 2017): i) Safety, consisted of skills development for in-the-moment distress levels; learning and practice of distress coping strategies; and assessment and treatment of safety concerns (e.g., suicidality, self-harm and substance abuse); ii) Psychoeducation around the symptomatic effects of trauma including PTSD and dissociative symptoms; iii) Assessment, conducted across one to six sessions was centered around the collaborative development of a written timeline of major life experiences (e.g., trauma, onset and development of PTSD and psychotic symptoms, suicidality and reduced functioning). While not designed as exposure treatment, comprehensive assessment of trauma can act as a form of covert exposure (Krakow, Hollifield, & Warner, 2000; van den Berg et al., 2015); and iv) Formulation, the collaborative conceptualisation of the relationship between the trauma and development of subsequent symptoms. How and when module sessions were delivered in relation to other case management tasks were flexible and largely determined by the needs of the client.

Procedure

Eleven participants who completed the intervention were recruited to the study, based on recommendations from guidelines regarding optimal sample size for IPA (Smith, Flowers, & Larkin, 2009). Contact was attempted with the first 15 participants who completed the trial however four were uncontactable after many attempts. Participants provided written consent and were reimbursed (AUD30) for their participation. All interviews were conducted and transcribed verbatim by JT. JT had no prior relationship with the participants before

conducting the research interviews. Interviews lasted between 15 and 75 minutes (average length of 47 minutes). Participant characteristics are presented in Table 2.

Insert Table 2 about here.

Interview

The semi-structured interview schedule consisted of open-ended questions to flexibly guide the interview (Smith & Osborn, 2007). The first question asked participants to reflect on their experience of the trauma intervention. Types of questions used to elicit responses were ‘Tell me about your experiences of...’. Statements such as “Tell me more about...” were used to invite participants to elaborate on their previous responses. When possible, participants’ own words were used in subsequent questions. Participants were asked to describe their experience of doing the timeline and to elaborate on their relationship with their case manager. KS and SB contributed to the development of the interview schedule. Interview questions were piloted on a young person (25 years) external to the study. The order and the delivery of the questions were modified, however the overall content of the interview schedule did not change as a result of the piloted interview.

IPA approach

In keeping the focus on the ‘voice’ of participants, and because its use is becoming increasingly common in research involving psychosis (e.g., Baron, Salvador, & Loewy, 2018; Dunkley, Bates, & Findlay, 2015), IPA was chosen as the methodology to analyse the data. Positioned within a critical realist perspective, IPA aims to explore meaning underlying experience (Reid, Flowers, & Larkin, 2005). This approach involves phenomenology and hermeneutics; where phenomenology is a philosophical approach to the study of human

experience and hermeneutics is the theory of interpretation (Smith & Osborn, 2007). Thus, there is firstly a focus on understanding the participant's experience and description of what it is like (e.g., experience of talking about trauma), then secondly an interpretative analysis whereby the description of the experience is positioned within a broader context.

Each transcript was divided into units, with a new unit beginning where there was a spontaneous shift in the meaning of the narrative. Commonalities in the units and initial notes were clustered to form emergent themes. This process was first completed for each transcript. Subsequently, emergent themes were identified and compared between transcripts. They were then redefined and renamed, and organised into a structure of superordinate and subordinate themes iteratively, guided by the data. Following this process, all themes were critically examined by KS, SB and JT, and any disagreements were discussed until consensus was reached. A number of themes were identified from the analysis. Themes related to participants' reactions in response to talking about trauma have been presented elsewhere (Tong et al., 2017). The current paper aims to explore participants' experiences of the processes of talking about trauma that are broader than symptom exacerbation and distress during the intervention. Themes from the previous paper will not be covered here.

Analysis was grounded in concrete verbatim extracts to illustrate the themes. Throughout the coding process, reflexivity within the first author was encouraged via regular discussion with the research team, and the use of a reflexive diary, allowing for any reactions, biases or assumptions to come to the foreground. The analysis followed the guidelines for IPA (Smith et al., 2009) and for the publication of qualitative studies (Tong, Sainsbury, & Craig, 2007) to ensure research credibility.

Results

ID numbers are used to protect participant confidentiality. Participants described challenging experiences during the intervention, as well as factors and processes that aided the course of the intervention. Participants described their experience of processes involved in the discussion of their trauma memories with their case manager. Also described were factors that facilitated the course of the intervention. The structure of the superordinate and subordinate themes is outlined in Table 3.

Insert Table 3 about here

Superordinate theme 1: Reluctance to approach the trauma memory

Nine out of eleven (82%) participants described experiencing reluctance during the process of their trauma assessment and intervention.

1a. Not wanting to talk about trauma. Five participants (45%) described initial feelings of not wanting to talk about their trauma. Participants articulated this was largely due to a desire to not think about the trauma, preferring to forget rather than delve into any memories.

“It’s just, it’s so...it’s difficult because [sigh] like you don’t want to talk about what went on in your life. You don’t wanna talk about the bad stuff. You wanna forget about it.” [P8]

1b. Difficulty acknowledging that the trauma had occurred. For three participants (27%), talking about past traumatic experiences meant first having to acknowledge that the trauma had occurred. Participants described having to “admit” or “accept” within themselves, the existence of their traumatic past.

“I was just scared to admit it all to myself really. As soon as we got to [talking about the abuse], I just couldn’t go on. I just couldn’t face it myself.” [P2]

Furthermore, two participants had worked to “store” or “push” their trauma memories away, and the trepidation in having to revisit those memories contributed to feelings of reluctance about talking about their trauma.

“It was tough because it’s you know they’re like memories I’ve stored away sort of thing and [I] had to go back through them all and...it’s like part of me wanted to just never ever go there again and it was hard.” [P5]

1c. Not wanting to re-experience emotions associated with the trauma. Four participants (36%) reported not wanting to experience the emotions (sadness, anger and fear) and appraisals associated with their trauma, which often arose when they spoke about their trauma with their case manager. For one participant, this resulted in missed appointments and disengagement with their case manager.

Three participants’ used words such as “confess” and “hiding” suggesting their appraisal of their trauma was of a wrongful or shameful nature, and these feelings of shame impeded the process of sharing their trauma memories.

“I was ashamed. I was ashamed of what had happened and I hadn’t told anyone. I’d just, it’s embarrassing. Especially from young. You don’t feel like telling anyone. Just disgusting.” [P7]

Superordinate theme 2: Factors aiding the process

Three subthemes formed the superordinate theme of what aided participants in working through the challenges of the intervention. The first subtheme is related to the participants’ internal experience and the remaining subthemes are related to attributes or actions driven by the clinician.

2a. Desire for change. Six participants (55%) described a desire for change was the driving factor behind continuing trauma treatment despite encountering difficulties (e.g., feeling reluctant during treatment). This desire was focused towards wanting to be happy, to get better, to have a fulfilling future, and to feel “normal”.

“...my motivation was having a better life. Feeling the way I’ve never felt before. Being successful...I need to take a stand for myself.” [P8]

For three participants, their desire for change was coupled with self-discovery, making sense of the past so they could move forward, and taking ownership of how they could make change in their life.

“This is my time to sort out my life.” [P5]

“I wanted to grow, I wanted to learn, I wanted to let those parts of my life go.” [P11]

2b. Not being pushed to talk about trauma. Eight participants (73%) appreciated how they were not pushed by their case managers to talk about their trauma. Four participants described how their case managers allowed them to dictate the pace of when to share details of their trauma history, as well as the amount of detail shared. This appeared to help orient the participants to the process of sharing in therapy and also developed their autonomy in the therapy space.

“I’m thankful she didn’t try and force me to be more talkative at the start.” [P6]

The notion of being “pushed to talk” and the repercussions of doing so were emphasised particularly strongly by two participants.

“If [details about my traumas are] made to come out of me, I know I won’t talk to you. I’ll stop attending the sessions. That’s it, I’m done. I can’t, I won’t talk anymore.” [P11]

It was evident from the transcripts that instances of being “pushed to talk” did not occur during the intervention.

“We didn’t jump into [talking about trauma] straight away. They didn’t expect me to pour my heart and soul out.” [P2]

Participants described case managers using techniques such as asking for permission to continue talking about a certain topic and regularly monitoring participant distress (e.g., checking in with participants’ emotions either conversationally or asking for a subjective units of distress rating) as ways of pacing the discussion about their trauma memories.

“[My case manager] kept reminding me “We can stop anytime, we don’t have to go any further”, she reminded me that if she sees that I’m going through something more stirring.” [P3]

2c. Valuing the case manager. All participants valued the role of their case manager, and four participants (36%) likened their relationship to their case manager as similar to a friendship or for one participant, to having an older sibling (*“...a bigger sibling...quietly listening to you and looking out for you” [P3]*).

The ability to share trauma memories with their case manager was a sign of the level of trust attained in the therapeutic relationship.

“I did trust her so I told her what had happened”. [P7]

Connecting through a sharing of personality and seeing their case manager as having their own identity helped to develop the therapeutic relationship.

“It was nice to make them...a fully formed person who has their own interests and their own life. That makes it easier to talk to them.” [P11]

Furthermore, five participants (45%) described sharing an emotional closeness with their case manager that helped to make their case manager more relatable, and also balanced the power dynamic between clinician and client.

“I’d be talking about something and I’d look up and there’s a tear... I couldn’t believe that [my story] had touched her.” [P5]

The importance of particular case manager attributes such as demonstrating competence (*“She had all the clinical knowledge [from seeing] so many clients and the wisdom from that” [P3]*), non-judgment (*“...I had this trust that you know I could just openly talk about anything whatever it was and she wouldn’t judge me” [P5]*), and confidentiality (*“She was always like “Now this is an environment where you can speak, it won’t go anywhere”. And when she used to say that, it used to help me just calm down and be able to talk” [P2]*) resonated throughout the transcripts.

For four participants (36%), continuing treatment despite their reluctance to share their trauma memories related to the support they were receiving from their case manager, which may have alleviated feelings of loneliness.

“...the fact that I had someone to talk to.” [P10]

2d. Time. The significance of time was weaved throughout participants’ transcripts. Descriptions from eight participants (73%) suggested there was a temporal element to building the therapeutic relationship, as the trust and emotional connection shared between participant and case manager were not achieved instantaneously. Furthermore, having ample time was crucial to case managers not pushing their participants to share their trauma memories, and for participants’ feelings of ‘not wanting to talk’ to ease.

“The more times I saw her, the easier it was for me to start talking to her.” [P6]

Seven participants’ (67%) described how their reluctance to engage in trauma-related content shifted with time suggesting there were temporal effects to the processes of talking about trauma. Three participants initially felt “closed up” before reaching a stage where they felt more comfortable sharing their trauma memories. The analogy of the case manager “breaking away at a wall” was used to describe the lead up to this as slow and laborious.

“[Talking about my trauma] had to be chiselled away at. Like slowly, need to be like, brought out.” [P11]

Discussion

Results showed that participants frequently expressed a sense of ‘*not wanting to talk about trauma*’ in a variety of ways. It is likely that post-traumatic avoidance was the source of ‘*not wanting to*’ think about, accept the existence of, or feel emotions associated, with the trauma experience. Post-traumatic avoidance pertains to the cognitive, affective and/or behavioural avoidance of trauma-specific stimuli as a way of evading otherwise overwhelming emotions (Foa, Riggs, & Gershuny, 1995). Theories of the relationship between trauma and psychosis highlight the centrality of post-traumatic stress processes (e.g., avoidance) (Bendall et al., 2012; Hardy, 2017).

Our data gives insight into the subjective experience of avoidance, highlighting the experience of having “stored away” memories [P5] and feeling reluctant in having to retrieve those memories. Alongside reluctance, participants also expressed a strong desire for change. This ambivalence also has been described in participants’ experience of the exposure component of trauma-focused CBT (Shearing, Lee, & Clohessy, 2011). Lack of motivation to

engage fully or ambivalence in relation to a behavioural change (i.e., talking about trauma) has been conceptualised as a problem of readiness (Cook, Dinnen, Simiola, Thompson, & Schnurr, 2014; Osei-Bonsu et al., 2017).

Readiness

Readiness refers to an individual's level of psychological 'preparedness' to undertake tasks associated with engaging in, and utilising the provisions of psychological therapy (Ogrodniczuk, Joyce, & Piper, 2009). Factors contributing to readiness have been suggested to be a willingness to engage in treatment; an openness to revealing painful feelings and experiences; perseverance; coping skills; safety and stability (psychiatric and physical); and motivation for treatment (Cook, Simiola, Hamblen, Bernardy, & Schnurr, 2017; Ogrodniczuk et al., 2009).

Not feeling "emotionally ready" (p. 281) for the perceived difficulty of talking about trauma-related content contributed to not seeking treatment for PTSD symptoms in 35% of 143 veterans (Stecker, Shiner, Watts, Jones, & Conner, 2013). In fact, the perception of need for readiness before exposure-based treatment in veteran groups is so great that the provision of pre-treatment preparatory groups to determine and enhance veterans' readiness is almost universal amongst clinics treating PTSD in veterans (Hamblen et al., 2015).

Despite the fact that lack of readiness seems to be a barrier for engaging in trauma treatment, it has not been widely researched. This is likely because lack of readiness is not highly apparent in clinical research trials, whereby the study design may be implicitly selecting in individuals who are more ready for treatment. Participation refusal may be related to higher levels of trauma and avoidance (Berry, Ford, Jellicoe-Jones, & Haddock,

2013) as less ready participants may decline research trials as they know it will involve a thorough assessment of PTSD, or a discussion of the trauma in detail. Foa and colleagues (2013) acknowledged this may have occurred in their trial involving adolescent female sexual abuse survivors, where their design may have “excluded inappropriate participants and [included] more motivated ones” (p. 2656). Participants showed trauma symptom reduction and good engagement after only one to three preparatory sessions before prolonged exposure, and this data was used to suggest that preparation is not needed for young people with PTSD from complex interpersonal traumas (Foa et al., 2013). Their methodology however, suggests their pool of participants may have been biased towards individuals who were ready for treatment and thus may have had less need for a preparatory phase.

This directly taps into a contentious issue regarding the necessity of a preparatory phase before exposure-based treatment. A preparatory phase has been recommended for complex presentations of PTSD to address psychiatric symptoms and skill development before starting emotionally-demanding exposure-based treatment (Cloitre et al., 2012). Skills-based components implemented prior to PTSD treatments were endorsed by veterans as useful to enhance their self-efficacy for completing treatment (Hundt et al., 2015). However, a critical review suggested that the evidence for the effectiveness of a preparatory phase was weak and delayed access to exposure-based treatments (de Jongh et al., 2016). The preparatory phases in question have focused primarily on stabilisation, skill development in affect and interpersonal regulation (e.g., Cloitre, Cohen, & Koenen, 2011) as opposed to addressing issues of readiness as part of preparation for talking about trauma.

Being in control and having choice

Paradoxically, what fostered readiness to talk about their trauma memories in our participants was not being pushed to do so. Having control over how and when details of trauma memories were shared was important to our participants. Furthermore, the majority reported the value of not having to “jump into” [P2] intensive trauma content immediately. This was also reported by women with a history of childhood sexual abuse engaging in psychotherapy (Middle & Kennerley, 2001). Further, this is in line with self-determination theory, in that choice and opportunity for self-direction have been found to foster intrinsic motivation to engage in particular behaviours due to increased feelings of autonomy (Ryan & Deci, 2000).

Exposure-based treatments have been shown to be challenging to undergo for veterans, individuals with general PTSD and those with comorbid FEP (Chouliara et al., 2011; Hundt, Barrera, Arney, & Stanley, 2017; Tong et al., 2017). Not pushing clients and giving them some control of the pace of therapy may make trauma treatments easier to undergo for those who encounter difficulty. Furthermore, these actions minimise the opportunity for client distress and retraumatisation, and are in line with the core principles of TIC, in particular choice, collaboration and empowerment (SAMHSA, 2012).

Therapeutic relationship

Our findings support the centrality of the therapeutic relationship in TIC (Wilson, Hutchinson, & Hurley, 2017), trauma-specific treatment for complex trauma (Briere & Lanktree, 2013) and psychosis (EPPIC, 2010). Indeed, individuals with a history of childhood sexual abuse were found to emphasise the importance of the therapeutic relationship and the interpersonal qualities of their clinician more, whereas those with no

abuse history focused more on therapeutic techniques and treatment progress (Middle & Kennerley, 2001).

Specific aspects such as trust, emotional closeness, confidentiality and non-judgment were described as aspects that aided in deepening the therapeutic relationship in our sample. Our findings are congruent with other experiential accounts of what was valued in the therapeutic relationship within trauma-specific treatment (Chouliara et al., 2011; Dittmann & Jensen, 2014). In relation to readiness, ambivalence towards sharing sensitive information in therapy has been shown to be positively influenced by the quality of the therapeutic relationship and the length of time in treatment (Hall & Farber, 2001). Our participants experienced the development of the therapeutic relationship to increase their readiness to talk about trauma.

Clinical implications

Our results suggest that giving clients a sense of control in treatment by allowing them choice over how and when their trauma memories are shared is a good first step in moving towards more trauma-informed early psychosis services (SAMHSA, 2012). More specifically, the importance of readiness to talk about trauma in both the current and in previous studies suggest that motivational enhancement strategies such as Motivational Interviewing (MI) may play a role in trauma-specific treatments (Cigrang & Peterson, 2017; Cook et al., 2014). MI is designed to explore and resolve ambivalence about behavioural change, and its effectiveness in the treatment of substance abuse is well known (Smedslund et al., 2011). A recent review found some improvement in treatment initiation and engagement following the addition of MI as an adjunct for CBT for anxiety disorders (Randall & McNeil, 2017). To date, MI approaches in PTSD have focused on ambivalence regarding changing

PTSD symptoms or associated coping strategies in veterans (Murphy, Thompson, Murray, Rainey, & Uddo, 2009; Seal et al., 2012). A MI approach may be helpful in the preparation phase of many trauma-focused interventions specifically to raise motivation to talk about trauma. A MI conceptualisation may also be able to identify individuals who are ready for immediate exposure-based treatments versus those who need time to resolve ambivalence regarding talking about trauma. This may assist to resolve the tension between the pro- and anti- preparatory phase approaches described above, with only those who are assessed as ‘not ready’ to talk about trauma to undertake work on enhancing readiness, while others proceed immediately to exposure-based treatment.

Nine of 11 of our participants described feeling reluctant to talk about trauma, which we have conceptualised as lack of readiness. There may be specific reasons why such a large proportion of the participants in this study were not ready to talk about trauma. Young people with FEP often present to services for the first time in acute psychotic crisis with little understanding that their psychiatric symptoms may be trauma-related. This is in contrast to people who present to trauma services with a clearer understanding of the role of trauma in their symptomatology. Young people with psychosis may need more time to acclimate to trauma-specific treatment than those accessing trauma services.

Limitations and future directions

Four young people were uncontactable for recruitment into the study and it is possible they experienced the intervention more negatively compared to our sample, choosing not to have further engagement with the study. Future research should target treatment non-completers via the inclusion of qualitative assessment as part of randomised controlled trial

methodologies, as reasons for terminating treatment would add great value to service delivery. Our participants valued having control in the delivery of trauma treatment. However, these results may be self-fulfilling as the intervention was designed to be trauma-informed (with a priority on client choice and collaboration) and our participants reflected these trauma-informed elements as important. Lastly, our study was delivered in a specialised FEP service with sessions available within a two-year window of care. This approach to treatment would likely be unfeasible in a time-limited clinical service.

Conclusion

Our results suggest that the feeling of ‘not wanting to’ talk about trauma was common amongst the traumatised young people in the current study, and presented a barrier to trauma treatment. Our data provides some insight into how this process was facilitated. Giving clients control, and having sufficient time to foster client readiness and the therapeutic relationship was key. Incorporating motivational interviewing and trauma-informed elements into trauma-specific treatment may enhance support for both clients and clinicians, and lead to trauma symptoms being more consistently addressed in young people with FEP.

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References

- Bailey, T., Alvarez-Jimenez, M., Garcia-Sanchez, A. M., Hulbert, C., Barlow, E., & Bendall, S. (2018). Childhood Trauma Is Associated With Severity of Hallucinations and Delusions in Psychotic Disorders: A Systematic Review and Meta-Analysis. *Schizophr Bull.* doi:10.1093/schbul/sbx161
- Baron, J., Salvador, M., & Loewy, R. (2018). Experience of associative stigma in parents of adolescents at risk for psychosis. *Early Interv Psychiatry.* doi:10.1111/eip.12555
- Beghi, M., Peroni, F., Gabola, P., Rossetti, A., & Cornaggia, C. (2013). Prevalence and risk factors for the use of restraint in psychiatry: a systematic review. *Rivista di Psichiatria*, 48(1), 10-22.
- Bendall, S. (2014). *TRauma-Informed Psychotherapy for Psychosis (TRIPP): an overview*. Paper presented at the 9th International Conference on Early Psychosis, Tokyo, Japan.
- Bendall, S., Alvarez-Jimenez, M., Hulbert, C. A., McGorry, P. D., & Jackson, H. J. (2012). Childhood trauma increases the risk of post-traumatic stress disorder in response to first-episode psychosis. *Australian and New Zealand Journal of Psychiatry*, 46(1), 35-39. doi:10.1177/0004867411430877
- Bendall, S., Alvarez-Jimenez, M., Killackey, E., & Jackson, H. (2017). Trauma-integrated psychotherapy for psychosis (TRIPP). In M. Bush (Ed.), *Address Adversity: Prioritising adversity and trauma-informed care for children and young people in England* (pp. 313-323). London, UK: The YoungMinds Trust.

- Bernstein, E. M., & Putnam, F. W. (1986). Development, reliability and validity of a dissociation scale. *The Journal of Nervous and Mental Disease*, 174(12), 727-735.
- Berry, K., Ford, S., Jellicoe-Jones, L., & Haddock, G. (2013). PTSD symptoms associated with the experiences of psychosis and hospitalisation: A review of the literature. *Clinical Psychology Review*, 33(4), 526-538. doi:10.1016/j.cpr.2013.01.011
- Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D., Gusman, F. D., Charney, D. S., & Keane, T. M. (1995). The development of a Clinician-Administered PTSD Scale. *Journal of Traumatic Stress*, 8(1), 75-90.
- Brand, R. M., McEnery, C., Rossell, S., Bendall, S., & Thomas, N. (2017). Do trauma-focussed psychological interventions have an effect on psychotic symptoms? A systematic review and meta-analysis. *Schizophrenia Research*. doi:10.1016/j.schres.2017.08.037
- Briere, J., & Lanktree, C. (2013). *Integrative Treatment of Complex Trauma for Adolescents (ITCT-A) Treatment Guide*. Retrieved from Los Angeles:
- Chouliara, Z., Karatzias, T., Scott-Brien, G., Macdonald, A., MacArthur, J., & Frazer, N. (2011). Talking therapy services for adult survivors of childhood sexual abuse (CSA) in Scotland: perspectives of service users and professionals. *Journal of Child Sexual Abuse*, 20(2), 128-156. doi:10.1080/10538712.2011.554340
- Cigrang, J. A., & Peterson, A. L. (2017). Stepped-Care Approaches to Posttraumatic Stress Disorder: Sharpening Tools for the Clinician's Toolbox. *Pragmatic Case Studies in Psychotherapy*, 13(2), 142-153.
- Cloitre, M., Cohen, L., & Koenen, K. (2011). *Treating survivors of childhood abuse: Psychotherapy for the interrupted life*: Guildford Press.
- Cloitre, M., Courtois, C. A., Ford, J., Green, B. L., Alexander, P., Briere, J., . . . van der Hart, O. (2012). The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults.
- Cook, J. M., Dinnen, S., Simiola, V., Thompson, R., & Schnurr, P. P. (2014). VA Residential Provider Perceptions of Dissuading Factors to the Use of Two Evidence-Based PTSD Treatments. *Professional Psychology: Research and Practice*, 45(2), 136-142. doi:10.1037/a0036183
- Cook, J. M., Simiola, V., Hamblen, J. L., Bernardy, N., & Schnurr, P. P. (2017). The influence of patient readiness on implementation of evidence-based PTSD treatments in Veterans Affairs residential programs. *Psychological Trauma: Theory, Research, Practice, and Policy*, 9(Suppl 1), 51-58. doi:10.1037/tra0000162
- Cunningham, T., Shannon, C., Crothers, I., Hoy, K., Fitzsimmons, C., McCann, R., . . . Mulholland, C. (2016). Enquiring about traumatic experiences in psychosis: A comparison of case notes and self-report questionnaires. *Psychosis*, 8(4), 301-310. doi:10.1080/17522439.2015.1115542
- de Jongh, A., Resick, P. A., Zoellner, L. A., van Minnen, A., Lee, C. W., Monson, C. M., . . . Bicanic, I. A. (2016). Critical Analysis of the Current Treatment Guidelines for Complex PTSD in Adults. *Depression and Anxiety*, 33(5), 359-369. doi:10.1002/da.22469

- Dittmann, I., & Jensen, T. K. (2014). Giving a voice to traumatized youth-Experiences with Trauma-Focused Cognitive Behavioral Therapy. *Child Abuse & Neglect*, 38, 1221-1230. doi:10.1016/j.chiabu.2013.11.008
- Doering, S., Muller, E., Kopcke, W., Pietzcker, A., Gaebel, W., Linden, M., . . . Schussler, G. (1998). Predictors of relapse and rehospitalization in schizophrenia and schizoaffective disorder. *Schizophrenia Bulletin*, 24(1), 87-98.
- Dunkley, J. E., Bates, G. W., & Findlay, B. M. (2015). Understanding the trauma of first-episode psychosis. *Early Intervention in Psychiatry*, 9(3), 211-220. doi:10.1111/eip.12103
- EPPIC. (2010). *Australian Clinical Guidelines for Early Psychosis*. Melbourne: University of Melbourne.
- Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. *Community Connections*, 2(2), 1-18.
- Foa, E. B., McLean, C. P., Capaldi, S., & Rosenfield, D. (2013). Prolonged exposure vs supportive counseling for sexual abuse-related PTSD in adolescent girls: a randomized clinical trial. *JAMA: The Journal of the American Medical Association*, 310(24), 2650-2657. doi:10.1001/jama.2013.282829
- Foa, E. B., Riggs, D. S., & Gershuny, B. S. (1995). Arousal, numbing and intrusion: Symptom structure of PTSD following assault. *American Journal of Psychiatry*, 152(1), 116-120.
- Foa, E. B., Zoellner, L. A., Feeny, N. C., Hembree, E. A., & Alvarez-Conrad, J. (2002). Does imaginal exposure exacerbate PTSD symptoms? *Journal of Consulting and Clinical Psychology*, 70(4), 1022-1028. doi:10.1037//0022-006x.70.4.1022
- Frueh, B. C., Dalton, M. E., Johnson, M. R., Hiers, T. G., Gold, P. B., Magruder, K. M., & Santos, A. B. (2000). Trauma with the psychiatric setting: Conceptual framework, research directions, and policy implications. *Administration and Policy in Mental Health*, 28(2), 147-154.
- Gairns, S., Alvarez-Jimenez, M., Hulbert, C., McGorry, P., & Bendall, S. (2015). Perceptions of clinicians treating young people with first-episode psychosis for post-traumatic stress disorder. *Early Intervention in Psychiatry*, 9, 12-20. doi:10.1111/eip.12065
- Galletly, C., Castle, D., Dark, F., Humberstone, V., Jablensky, A., Killackey, E., . . . Tran, N. (2016). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders. *Australian and New Zealand Journal of Psychiatry*, 50(5), 410-472. doi:10.1177/0004867416641195
- Gray, M. J., Litz, B. T., Hsu, J. L., & Lombardo, T. W. (2004). Psychometric properties of the life events checklist. *Assessment*, 11(4), 330-341. doi:10.1177/1073191104269954
- Hall, D., & Farber, B. A. (2001). Patterns of patient disclosure in psychotherapy. *Journal of the American Academy of Psychoanalysis* 29(2), 213-230.
- Hamblen, J. L., Bernardy, N. C., Sherrieb, K., Norris, F. H., Cook, J. M., Louis, C. A., & Schnurr, P. P. (2015). VA PTSD clinic director perspectives: How perceptions of readiness influence delivery of evidence-based PTSD treatment. *Professional Psychology: Research and Practice*, 46(2), 90-96. doi:10.1037/a0038535

- Hardy, A. (2017). Pathways from Trauma to Psychotic Experiences: A Theoretically Informed Model of Posttraumatic Stress in Psychosis. *Frontiers in Psychology*, 8, 697. doi:10.3389/fpsyg.2017.00697
- Hundt, N., Barrera, T. L., Arney, J., & Stanley, M. A. (2017). "It's Worth It in the End": Veterans' Experiences in Prolonged Exposure and Cognitive Processing Therapy. *Cognitive and Behavioral Practice*, 24(1), 50-57. doi:10.1016/j.cbpra.2016.02.003
- Hundt, N. E., Mott, J. M., Miles, S. R., Arney, J., Cully, J. A., & Stanley, M. A. (2015). Veterans' perspectives on initiating evidence-based psychotherapy for posttraumatic stress disorder. *Psychological Trauma: Theory, Research, Practice, and Policy*, 7(6), 539-546. doi:10.1037/tra0000035
- Krakow, B., Hollifield, M., & Warner, T. D. (2000). Placebo Effect in Posttraumatic Stress Disorder. *JAMA: The Journal of the American Medical Association*, 284(5), 563.
- MHCC. (2014). *Recovery for Young People: Recovery orientation in youth mental health and child and adolescent mental health services (CAMHS): Discussion Paper*. Sydney, NSW.
- Middle, C., & Kennerley, H. (2001). A grounded theory analysis of the therapeutic relationship with clients sexually abused as children and non-abused clients. *Clinical Psychology and Psychotherapy*, 8(3), 198-205. doi:10.1002/cpp.280
- Morris, D. J. (2015). After PTSD, more trauma. *New York Times*.
- Mueser, K. T., Lu, W., Rosenberg, S. D., & Wolfe, R. (2010). The trauma of psychosis: posttraumatic stress disorder and recent onset psychosis. *Schizophrenia Research*, 116(2-3), 217-227. doi:10.1016/j.schres.2009.10.025
- Murphy, R. T., Thompson, K. E., Murray, M., Rainey, Q., & Uddo, M. M. (2009). Effect of a motivation enhancement intervention on veterans' engagement in PTSD treatment. *Psychological Services*, 6(4), 264-278. doi:10.1037/a0017577
- NICE. (2014). *Psychosis and schizophrenia in adults: prevention and management*.
- Ogrodniczuk, J. S., Joyce, A. S., & Piper, W. E. (2009). Development of the Readiness for Psychotherapy Index. *Journal of Nervous and Mental Disease*, 197(6), 427-433.
- Osei-Bonsu, P. E., Bolton, R. E., Wiltsey Stirman, S., Eisen, S. V., Herz, L., & Pellowe, M. E. (2017). Mental Health Providers' Decision-Making Around the Implementation of Evidence-Based Treatment for PTSD. *Journal of Behavioral Health Services & Research*, 44(2), 213-223. doi:10.1007/s11414-015-9489-0
- Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience. *The Psychologist*, 18(1), 20-23.
- Rodrigues, R., & Anderson, K. K. (2017). The traumatic experience of first-episode psychosis: A systematic review and meta-analysis. *Schizophrenia Research*. doi:10.1016/j.schres.2017.01.045
- Rosenberg, S. D., Lu, W., Mueser, K., Jankowski, M. K., & Cournos, F. (2007). Correlates of adverse childhood events among adults with schizophrenia spectrum disorders. *Psychiatric Services*, 58(2), 245-253.
- Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, 55(1), 68-78.

- SAMHSA. (2012). *SAMHSA's National Center for Trauma-Informed Care: Changing Communities, Changing Lives*. National Association of State Mental Health Program Directors
- Sampson, M., & Read, J. (2017). Are mental health staff getting better at asking about abuse and neglect? *International Journal of Mental Health Nursing*, 26, 95-104. doi:10.1111/inm.12237
- Schnyder, U., Ehlers, A., Elbert, T., Foa, E. B., Gersons, B. P., Resick, P. A., . . . Cloitre, M. (2015). Psychotherapies for PTSD: what do they have in common? *European Journal of Psychotraumatology*, 6, 28186. doi:10.3402/ejpt.v6.28186
- Seal, K. H., Abadjian, L., McCamish, N., Shi, Y., Tarasovsky, G., & Weingardt, K. (2012). A randomized controlled trial of telephone motivational interviewing to enhance mental health treatment engagement in Iraq and Afghanistan veterans. *General Hospital Psychiatry*, 34(5), 450-459. doi:10.1016/j.genhosppsych.2012.04.007
- Shearing, V., Lee, D., & Clohessy, S. (2011). How do clients experience reliving as part of trauma-focused cognitive behavioural therapy for posttraumatic stress disorder? *Psychology and Psychotherapy: Theory, Research and Practice*, 84(4), 458-475. doi:10.1111/j.2044-8341.2010.02012.x
- Sibitz, I., Scheutz, A., Lakeman, R., Schrank, B., Schaffer, M., & Amering, M. (2011). Impact of coercive measures on life stories: qualitative study. *British Journal of Psychiatry*, 199(3), 239-244. doi:10.1192/bjp.bp.110.087841
- Smedslund, G., Berg, R. C., Hammerstrom, K. T., Steiro, A., Leiknes, K. A., Dahl, H. M., & Karlsen, K. (2011). Motivational interviewing for substance abuse. *Cochrane Database of Systematic Reviews*, 5. doi:10.4073/csr.2011.6
- Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London, England: Sage.
- Smith, J. A., & Osborn, M. (2007). Interpretative Phenomenological Analysis. In J. A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods*: Sage.
- Stecker, T., Shiner, B., Watts, B. V., Jones, M., & Conner, K. R. (2013). Treatment-Seeking Barriers for Veterans of the Iraq and Afghanistan Conflicts Who Screen Positive for PTSD. *Psychiatric Services*, 64(3), 280-283. doi:10.1176/appi
- Steinert, T., Schmid, P., & Bergbauer, G. (2006). History of trauma in people with schizophrenia predicts need for seclusion and restraint. *Journal of Clinical Psychiatry*, 67(6), 995.
- Swan, S., Keen, N., Reynolds, N., & Onwumere, J. (2017). Psychological Interventions for Post-traumatic Stress Symptoms in Psychosis: A Systematic Review of Outcomes. *Frontiers in Psychology*, 8, 341. doi:10.3389/fpsyg.2017.00341
- Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19(6), 349-357.
- Tong, J., Simpson, K., Alvarez-Jimenez, M., & Bendall, S. (2017). Distress, Psychotic Symptom Exacerbation, and Relief in Reaction to Talking about Trauma in the Context of Beneficial Trauma Therapy: Perspectives from Young People with Post-

- Traumatic Stress Disorder and First Episode Psychosis. *Behavioural and Cognitive Psychotherapy*, 45(6), 561-576. doi:10.1017/S1352465817000236
- Trauelsens, A. M., Bendall, S., Jansen, J. E., Nielsen, H. G., Pedersen, M. B., Trier, C. H., . . . Simonsen, E. (2015). Childhood adversity specificity and dose-response effect in non-affective first-episode psychosis. *Schizophrenia Research*, 165(1), 52-59. doi:10.1016/j.schres.2015.03.014
- van den Berg, D. P., de Bont, P. A., van der Vleugel, B. M., de Roos, C., de Jongh, A., Van Minnen, A., & van der Gaag, M. (2015). Prolonged exposure vs eye movement desensitization and reprocessing vs waiting list for posttraumatic stress disorder in patients with a psychotic disorder: a randomized clinical trial. *JAMA Psychiatry*, 72(3), 259-267. doi:10.1001/jamapsychiatry.2014.2637
- Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer, W., . . . Bentall, R. P. (2012). Childhood adversities increase the risk of psychosis: a meta-analysis of patient-control, prospective- and cross-sectional cohort studies. *Schizophrenia Bulletin*, 38(4), 661-671. doi:10.1093/schbul/sbs050
- Walters, S., Hogg, L., & Gillmore, C. (2016). Evaluation of a tailored training programme to improve the assessment and treatment of trauma in an Early Intervention in Psychosis (EIP) service. *Psychosis*, 8(3), 226-237. doi:10.1080/17522439.2015.1131324
- Wilson, A., Hutchinson, M., & Hurley, J. (2017). Literature review of trauma-informed care: Implications for mental health nurses working in acute inpatient settings in Australia. *International Journal of Mental Health Nursing*. doi:10.1111/inm.12344

Table 1. Inclusion criteria for pilot trial

(a) DSM-IV psychotic disorder or mood disorder with psychotic features
(b) Age: 15 to 25
(c) current trauma symptoms (operationalised as meeting full criteria for PTSD via the Clinician Administered PTSD Scale (Blake et al., 1995); or dissociation at clinical levels on the Dissociative Experiences Scale (Bernstein & Putnam, 1986); or trauma exposure assessed using a life events checklist adapted for young people from the Life Events Checklist (Gray, Litz, Hsu, & Lombardo, 2004)) and the presence of psychotic symptoms related to that trauma (decided by research team consensus).

Table 2. Participant characteristics

ID	Age	Gender	Psychosis diagnosis	Type of trauma experienced
P1	19	F	Schizophrenia	Bullying
P2	19	F	Schizophrenia	Sexual abuse
P3	26 ^a	F	Bipolar I disorder with psychotic features	Bullying, physical abuse
P4	27 ^a	F	Schizoaffective disorder	Physical abuse, bullying, accidents, psychosis
P5	22	F	Bipolar I disorder with psychotic features	Psychosis, sexual abuse, physical abuse, emotional abuse
P6	19	F	Psychotic disorder	Bullying, psychosis
P7	25	F	Schizoaffective disorder	Sexual abuse, psychosis
P8 ^b	18	F	Unknown	Unknown
P9	18	F	Schizoaffective disorder	Psychosis
P10	20	M	Schizophrenia	Psychosis
P11	21	M	Schizoaffective disorder	Physical abuse, psychosis

^aP3 and P4 were aged under 25 years old when their two-year episode of care commenced at the service.

^b Due to overwhelming levels of distress, P8 was unable to complete baseline and follow up assessments however still wanted to receive the intervention.

Table 3. Superordinate and subordinate themes related to participants' experiences of treatment

Superordinate themes	Subthemes
1. Reluctance to approach the trauma memory	1a. Not wanting to talk about trauma 1b. Difficulty acknowledging that the trauma had occurred 1c. Not wanting to re-experience emotions associated with trauma
2. Factors aiding the process	2a. Desire for change 2b. Not being pushed to talk 2c. Valuing the case manager 2d. Time