



'I do not know where it comes from, I am suspicious of some childhood trauma' association of trauma with psychosis according to the experience of those affected

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ABSTRACT

Background: Trauma-related symptoms are often experienced after a first psychotic episode.

Objective: In this study, we conduct a qualitative analysis of referred traumatic experiences of outpatients diagnosed with psychotic disorders.

Method: Focus groups were formed and in-depth interviews conducted with 30 participants, focusing on their experience with the disorder and the health care received. Given the frequency with which trauma and psychosis have been associated in the scientific literature, the nature of this relation is addressed as a secondary objective, via a qualitative analysis.

Results: Analysis revealed two main themes in the patients' discourse. On many occasions, traumatic experiences were related to the development of the disorder. Although most participants referred to traumatic experiences during childhood, episodes during adult life were also reported, which may have triggered the disorder. The second theme was that of the interlocking relationship between the psychotic experience and certain coercive practices undergone during the provision of health care for psychosis, and the traumatic effects thus generated.

Conclusions: The participants considered both themes to be highly important. Accordingly, these issues should be carefully assessed and managed in order to provide appropriate person-centred care.

'No sé de dónde viene, sospecho de algún trauma infantil' Asociación de trauma con psicosis según la experiencia de los afectados

Antecedentes: Los síntomas relacionados con el trauma a menudo se experimentan después de un primer episodio psicótico.

Objetivo: En este estudio, realizamos un análisis cualitativo de experiencias traumáticas de pacientes ambulatorios diagnosticados con trastornos psicóticos.

Método: Se conformaron grupos focales y se realizaron entrevistas en profundidad a 30 participantes, enfocándose en su experiencia con el trastorno y la atención médica recibida. Dada la frecuencia con la que el trauma y la psicosis se han asociado en la literatura científica, la naturaleza de esta relación se aborda como un objetivo secundario, a través de un análisis cualitativo.

Resultados: El análisis reveló dos temas principales en el discurso de los pacientes. En muchas ocasiones, las experiencias traumáticas se relacionaron con el desarrollo del trastorno. Aunque la mayoría de los participantes se refirieron a experiencias traumáticas durante la infancia, también se informaron episodios durante la vida adulta, los que pueden haber desencadenado el trastorno. El segundo tema fue el de la relación entrelazada entre la experiencia psicótica y ciertas prácticas coercitivas sufridas durante la prestación de atención médica para la psicosis, y los efectos traumáticos generados por ésta.

Conclusiones: Los participantes consideraron que ambos temas eran de gran importancia. En consecuencia, estas situaciones deben evaluarse y gestionarse cuidadosamente para proporcionar una atención adecuada centrada en la persona.

'我不知道它来自哪里,我怀疑是一些童年创伤'根据患者经历的创伤与精神病的关联。

背景: 创伤相关症状常在第一次精神病发作后出现。

目的: 在本研究中,我们对诊断有精神障碍的门诊患者提及的创伤经历进行了定性分析。

方法: 形成了焦点小组并对 30 名参与者进行了深入访谈,重点关注其疾病经历和接受的健康护理。鉴于科学文献中创伤和精神病相关的频繁性,此关系的性质被视为通过定性分析的主要目标。

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HIGHLIGHTS

- A qualitative analysis was conducted of the association between trauma and psychosis.
- Participants identified early-life trauma, such as child abuse, as the origin of their disorder.
- Further trauma was generated by experiences after the onset of psychosis, including practices in health care settings.

结果: 分析揭示了患者论述中的两个主要主题。在许多情况下, 创伤经历与疾病发展相关。虽然大多数参与者提到了童年期创伤经历, 也报告了成年生活中的事件, 这可能触发了疾病。第二个主题是精神病经历与在精神病健康护理期间所经历的某些强制做法之间的连锁关系, 以及由此产生的创伤影响。
结论: 参与者认为这两个主题都非常重要。因此, 应仔细评估和管理这些问题, 以提供适当的以人为本的护理。

1. Introduction

Schizophrenia, a serious mental disorder that is often associated with a chronic course, is among the fifteen leading causes of disability, according to a global survey (GBD 2016, D. and I. I. and GBD 2016 D. and I. I. and P. C., 2017). Although the disorder is uncommon, its prevalence increases significantly when the entire psychotic spectrum is included. A recent systematic review obtained pooled median point and 12-month prevalence values for psychotic disorders of 3.89 and 4.03 per 1000, respectively, with a median lifetime prevalence of 7.49 per 1000 (Moreno-Küstner, Martín, & Pastor, 2018). Furthermore, psychotic disorders are frequently associated with other psychopathological conditions, both during the first episode and throughout the course of the disorder (Buckley, Miller, Lehrer, & Castle, 2009; Hoertel et al., 2019; Singh, Beniwal, Bhatia, & Deshpande, 2019; Siu, Chong, & Lo, 2018; Tsai & Rosenheck, 2013). About 40% of patients with a first psychotic episode (FPE) have a current psychic comorbidity recorded in their medical history (Siu et al., 2018). Numerous studies have shown that, with respect to the general population, adults diagnosed with schizophrenia are more likely to suffer anxiety, depression, obsessive symptoms and substance use disorders (Buckley et al., 2009; Hoertel et al., 2019; Singh et al., 2019; Tsai & Rosenheck, 2013). Moreover, individuals with an ultra-high risk of psychosis present high comorbidity rates for anxiety and/or obsessive-compulsive or mood disorders (Albert, Tomassi, Maina, & Tosato, 2018), which suggests that this kind of disorder may precede the psychotic disorder. Following a FPE, approximately half of all patients experience post-traumatic stress disorder (PTSD) symptoms, and one in three experience full PTSD (Rodrigues & Anderson, 2017).

This high rate of comorbidity might be explained by exposure to trauma, which has been reported by up to 80% of persons with psychotic symptoms (Catalan et al., 2017; Frissen, Lieverse, Drukker, van Winkel, & Delespaul, 2015; Gabínio et al., 2018; Luutonen, Tikka, Karlsson, & Salokangas, 2013; Turner et al., 2019). In fact, childhood trauma has been extensively investigated as a major risk factor for the development of psychosis in adult life (Catalan et al., 2017; Frissen et al., 2015; Gabínio et al., 2018; Luutonen et al., 2013; Turner et al., 2019). In addition, exposure to

childhood trauma has been associated with worsened health outcomes (Klarić & Lovrić, 2018; Turner et al., 2019).

Another area that has recently been addressed in the scientific literature is that of the emotional impact of a FPE and its possible traumatic effect, which may go beyond PTSD (Auxéméry, 2018; Dunkley, Bates, & Findlay, 2015). Specifically, 'traumagenic' distress is characterized by the presence of a range of negative emotions. Thus, the impact of FPE is viewed as an ongoing process, not limited to the acute episode. In consequence, it may affect the personality, disrupting the patient's self-identity, relationships and worldview (Auxéméry, 2018; Dunkley et al., 2015).

Most previous studies of this question have employed quantitative methodologies. To our knowledge, very few have analysed the relationship between psychotic disorders and trauma using qualitative methods. Accordingly, the main aim of the present study is to conduct a qualitative analysis of trauma-related themes associated with psychosis, from the standpoint of those affected.

2. Method

2.1. Design

Descriptive qualitative study of data obtained from focus group analysis.

2.2. Participants

The study was conducted at the Mental Health Service of the Regional University Hospital of Málaga (Spain), which attends over 8,000 patients a year, including over 1,200 patients with some kind of psychotic disorder.

Patients were selected for inclusion in this study according to the following criteria: prior diagnosis of psychotic disorder by a psychiatrist or clinical psychologist, in accordance with DMS-V criteria (APA, 2013); attended by the mental health services of the Spanish National Health System; no active symptoms (at the beginning of the study) that might influence their participation. All participants were aged at least 18 years and not subject to intellectual disability.

Purposive sampling was performed, in line with the above criteria, from the complete electronic medical records of patients with a diagnosis of psychotic

disorder. Those selected for inclusion were contacted by their mental health nurse, who explained the study goals and requested their participation. The patients who agreed to take part were called to attend before the meeting's scheduled start, with sufficient time for them to read the patient information sheet and to ask any questions considered relevant. Signed informed consent was then obtained. The sample size was determined according to the principle of information saturation during data collection and analysis, in other words, until new discourses on the main topics being investigated ceased to appear.

Before achieving information saturation, 46 possible participants were identified and contacted. Five refused to participate, and another eleven were unable to attend the scheduled appointments for the focus groups and/or interviews. The final rate of participation, therefore, was 65.22%.

The sample was composed of 30 participants, 15 men and 15 women. Twenty-four had been diagnosed with schizophrenia, four had a schizoaffective disorder, one had a psychotic disorder and one had a persistent delusional disorder (See Table 1).

For the purposes of this study, three focus groups were formed and four in-depth interviews conducted, three of which were with members of the focus groups.

The first focus group was composed of eleven persons (six men and five women), the second, of eight (two men and six women) and the third, of ten (six men and four women). The only group segmentation criteria applied were that the numbers of male and female participants should be approximately equal and that none of the participants should know each other.

2.3. Procedures

The data collection technique used, thus, was focus groups and individual in-depth interviews. The interviews were semi-structured and supported by a guide (Appendix). Issues identified in the literature (National Institute for Mental Health and Care Excellence, 2011), together with expert consultations and findings from previous studies carried out in our hospital department (Hurtado et al., 2020) were taken into consideration in drafting the interview guide. The following topics were included in the guide: the impact of the disorder on daily life and interpersonal relationships; the relationship with health care personnel (in both primary care and mental health services); the types of interventions offered by the public health system (including psychological and/or pharmacological options) and their perceived impact; and the personal resources developed to cope with the disorder. The questions were open-ended and the interview was conducted in a flexible style, so that any topic, even if not initially proposed, could be accepted and discussed. The interviews lasted between 90 and 120 minutes and were conducted by neutral interviewers who were experts in group and individual interview techniques and were not related to the treatment team involved. Every interview was witnessed by a trained observer, who was also unrelated to the treatment team. The interviews were held at a different location from where usual treatment was provided.

2.4. Content analysis

The interviews were audio-taped and transcribed verbatim. A content analysis was performed in accordance with established principles (Taylor, Bogdan, & DeVault, 2015). The data obtained were read multiple times to ensure familiarization with the discourses. The emerging themes were identified after several readings of the interview transcripts. Events considered to be significant were then coded by a member of the research team and the resulting codes were triangulated following their review by another two members of the research team. Any differences in the codes proposed were discussed among the team until a final agreement was obtained. The codes were grouped into categories and subcategories and analysed bearing in mind the potential influence of the researchers themselves.

Table 1. Characteristics of the participants.

I.D.	Sex	Age	Diagnosis	Age of onset
G1P1	Male	40	Schizophrenia and recurrent depressive disorder	22
G1P2	Female	42	Schizophrenia	18
G1P3	Female	49	Schizoaffective disorder	20
G1P4	Female	37	Schizophrenia	Unknown
G1P5	Female	38	Schizophrenia and schizotypal disorder	17
G1P6	Male	37	Schizophrenia	20
G1P7	Male	33	Schizophrenia	18
G1P8	Female	43	Schizophrenia	20
G1P9	Male	31	Psychotic disorder	24
G1P10	Female	50	Schizophrenia	29
G1P11	Male	43	Schizophrenia and schizotypal disorder	22
G2P1	Female	63	Persistent delusional disorder and recurrent depressive disorder	39
G2P2	Female	54	Schizophrenia	28
G2P3	Female	29	Schizoaffective disorder	24
G2P4	Male	48	Schizophrenia	31
G2P5	Female	45	Schizophrenia	33
G2P6	Female	55	Schizophrenia and recurrent depressive disorder	33
G2P7	Female	59	Schizophrenia and recurrent depressive disorder	34
G2P8	Male	68	Schizophrenia	30
G3P1	Male	50	Schizophrenia	24
G3P2	Male	41	Schizophrenia	14
G3P3	Female	50	Schizophrenia	32
G3P4	Male	51	Schizophrenia	41
G3P5	Male	42	Schizophrenia	Unknown
G3P6	Male	24	Schizoaffective disorder	22
G3P7	Female	59	Schizoaffective disorder	30
G3P8	Female	49	Schizophrenia and recurrent depressive disorder	27
G3P9	Male	41	Schizophrenia	27
G3P10	Female	51	Schizophrenia	30
EP1	Male	33	Schizophrenia	17

To corroborate the validity of the results obtained, the criteria of credibility, transferability, consistency and confirmability were applied, as recommended by Guba and Lincoln (2000). The credibility of the analysis process was supported by triangulating the codes and categories employed. Transferability was strengthened by ensuring the completeness of data collection in each group, across multiple potential situations, scenarios and experiences with psychotic disorder. The criteria of data consistency and reproducibility were met by means of a detailed, fully documented analysis strategy, taking into account the context in which data collection took place. With a view to obtaining confirmability and reflexivity, the research team members all conducted a prior analysis of their own preconceptions and expectations regarding the main study aims. Finally, the person conducting the interviews was neutral, highly experienced in the performance of qualitative interviews and did not form part of the research team.

2.5. Ethical considerations

The study was approved by the Malaga Provincial Committee for Research Ethics. All participants were informed, verbally and in writing, of the characteristics and aims of the study before their consent to participate in this research was requested. The principles of good practice and the provisions of the Declaration of Helsinki and its subsequent revisions were fully complied with throughout the study. All study data were treated confidentially and anonymized for the analysis.

3. Results

Of the thirty participants, fourteen reported having experienced one or more traumatic experiences. Of these fourteen, eleven referred to traumatic experiences before the onset of the disorder (nine had had traumatic experiences in childhood, and two at the beginning of adult life, close to the onset of the disorder, and which had acted as precipitants, according to their report). The other three participants had experienced traumatic experiences during hospitalization and/or resulting from the psychosis itself. One participant had suffered trauma-related experiences both before and after the onset of the disorder.

Most of those who reported traumatic experiences related to the origin of the disorder, observed that this experience had occurred during childhood or at the beginning of adult life, close to the onset of the disorder. They perceived this experience as a factor associated with their vulnerability to developing the disorder or as a precipitating factor. For the remaining participants, their traumatic experiences were the consequence of hospitalization and of the psychosis itself. Thus, two main themes can be distinguished:

a majority one, in which trauma is viewed as the origin (or part of the origin) of the psychotic disorder; and a lesser theme, which ascribed the trauma to the disorder and/or the habitual treatment provided, with particular regard to coercive measures, such as restraint or seclusion.

3.1. Trauma before psychotic disorder

Approximately a third of the people interviewed reported having lived in an unstructured family during their childhood and the majority reported having suffered abuse in their own home:

My mother beat me up because I didn't get up and just wanted to sleep . . . (Man, 33)

My case is of continued mistreatment for many years (Woman, 59)

Since I was 8 years old, I took drugs . . . dipotassium clorazepate, alprazolam . . . because I had a conflictive family . . . my father was an alcoholic and gave us a bad life . . . (Man, 50)

There were many arguments between my father and my mother, at home . . . It affected me a lot. And also, what was happening there, in Algeria (referring to the civil war between 1991 and 1997) . . . This may be one of the reasons for my schizophrenia. (Man, 41)

The participants who had lived through these circumstances usually related them unambiguously with the subsequent appearance of the disorder:

I don't know where it comes from, I suspect there was some childhood trauma, of several bad things that happened to me, that they did to me and . . . and it could be everything, a basic character that is not correct, that is not normal . . . and that harmed me. (Man, 68)

. . . Everything comes from childhood, that's at the root of it. (Woman, 59)

Because I think everything is . . . my mother treated me very badly. My mother treated me very badly. She called me a faggot, a homosexual . . . I can tell you that my mother, I was sleeping in the bed near her, I was ill and she kicked me because I was coughing and she couldn't sleep. She smoked joints. She beat me up. She's been a very bad mother. (Man, 33)

We lived in an old house, with rats, bedbugs, fleas . . . in poverty. What happened to me was a trauma that I suffered as a child, because my house was torn down, my father got sick and died. So, my mother and I were left alone. She wasn't well. She had no identity documents. She had been in an asylum . . . It started there. And it all started with that situation. Me, homeless . . . and my mother, in the homeless shelter . . . Alone. (Man, 50)

In addition, some participants referred to a maternal attitude of continuous disapproval, but falling short of abuse. The experience caused great suffering during

their childhood, although this fact was not so clearly related with the onset of the disorder:

What happened to me with my mother was that I used to do things in a way that wasn't what she wanted, and she always compared me to other people. "That girl seems more like my daughter than you". She had a way of thinking that, for me . . . It tears you apart . . . people you depend on and that you love, but who don't like the way you are. (Woman, 42)

My mother said: 'Help me do this' and maybe I couldn't the first time she asked, or the second time. By the third or fourth, I could have done it. Well, she used to tell me once and, if I couldn't do it, she told me straight away 'You don't know, you don't know how to do anything. I have to do it by myself.' She never gave me another chance. (Woman, 37)

A few participants also related traumatic events in their adult life with the onset of the psychotic disorder, in their case, these events precipitated the disorder. For example, one participant was a lawyer. Her brother had drug addiction problems and she had to care for him before her disorder began, dealing with people from that world, and paying off his debts. This is what she said:

Years later, I think that I went through an internal struggle. Staying in bed, not moving all day, not cleaning or anything else. And the internal fight was between the police and the drug dealers, the criminals and the police. Because I knew about both sides and I was in the middle. Almost every time I've been through a psychotic episode, it's been due to this context I experienced . . . (Woman, 49).

3.2. Trauma associated with the experience of hospitalization in a psychiatric ward and with the psychosis itself

Some participants reported symptoms related to a post-traumatic stress disorder following unpleasant experiences in health care settings, especially those related to the use of coercive measures. The experience of physical immobilization was described as a situation of maximum vulnerability and helplessness. Even after their recovery from psychotic symptoms, the feeling of insecurity persisted for months. For example, one young woman told how she felt when an A&E orderly chased and immobilized her after she ran in terror across the street, in a state of apparent perplexity, shortly after her first psychotic episode:

My mother called the emergency service and they came with the ambulance. Suddenly there was a man who wanted to take me away. I said: 'No, let me go . . . where did this man come from?' I thought they wanted to kidnap me. And the truth is that this man wasn't gentle, but what do I know, maybe in that situation . . . Maybe he didn't know about this problem either. I ran away and the guy caught me, threw

me to the floor. He put his knees on my arms and administered a sedative through my nose. So that's what has been traumatizing me for at least eight or nine months after I left the hospital . . . That. The feeling of helplessness. (Woman, 29)

It was like 'I'm afraid of this man, this man is going to kidnap me and he has kidnapped me, and I can't do anything.' (nervous laugh). There was no possible defence. That if there is someone on the street who wants to do something to me, then they're going to do it, because there's nothing I can do. (Woman, 29)

Another sensation that some participants reported, which gave them a bad experience during hospitalization, was that of being reified. They described how, although from the outside it might seem that, in moments of perplexity or blockage, they are not capable of understanding, subjectively, in fact, they are. So, when they aren't treated as someone with the ability to reason, they may interpret the situation in the most paranoid sense (in line with their paranoid tendency). In other words, treatment that they perceive as inhuman is associated with a dramatic situation such as kidnapping, which further increases their psychological distress. The same participant related her experience in this regard in great detail in an in-depth interview:

In one of these episodes, five or six people took hold of me and laid me down on a bed. I didn't even know what they were going to do to me. And they gave me a lumbar puncture . . . And my first impression was . . . What the fuck! They treated me like an object. They didn't explain anything. They didn't even say, 'Look, let's do this or that.' Not even a word of understanding. 'Look, don't worry. Nothing bad is going to happen'. (Woman, 29)

They treated me like a madwoman . . . like, 'I'm not going to explain it to you, because you won't understand.' It's true, from outside it may seem that I don't have the ability to reason, but nobody had ever treated me like that before. (Woman, 29)

This feeling of helplessness has caused some users to run away from health service attention:

They took me to the hospital, and I ran away. The police came and tied me up. I ran away as soon as I could. Anyway, a story. (Man, 51)

In addition, some participants did not remember what had happened, or only vaguely. They did not want to remember what those days had been like or what had happened during hospital admission a few years previously, but they did express strong rejection of this experience. For example, one man reported conscious forgetfulness of the days when he was hospitalized:

I was admitted for two days because my parents were worried. And they took me to the hospital . . . and I was there for two or three days. But don't ask me what happened there, because I don't remember very much. I do remember cigarettes were given out to

everyone, and when you went outside . . . But I don't have any memories of life there inside . . . All that year I have it as . . . I don't know if the brain gets over it by forgetting . . . I never want to live those times again. (Man, 48)

Moreover, recovering from psychosis and being aware for the first time of what they themselves have lived through and what could have happened if no health intervention had been made, is an experience that generates intense fear in many people, often leading to post-psychotic depression:

It scared me a lot, to say 'It beats me! It's just that I've been crazy, and I didn't realize it' . . . It's just that I could have stayed that way all my life and I wouldn't have realized. (Woman, 29)

4. Discussion

The main aim of this study was to analyse the trauma-related content of speech in a qualitative study and to consider its association with psychosis, from the standpoint of the persons most directly affected. The results obtained show that trauma-related issues are present in the spontaneous speech of many people diagnosed with psychotic disorders. This finding corroborates previous research according to which a large proportion of mental health services users, in their first consultation, spontaneously report having suffered traumatic events (Lothian & Read, 2002).

The subject most frequently referred to by the persons interviewed in this study was that of trauma suffered before the FPE. In some cases, it was suggested that these experiences might have provoked (entirely or in part) the subsequent development of a psychotic disorder. In fact, childhood trauma has been extensively investigated as a major risk factor for the development of psychosis in adult life (Catalan et al., 2017; Frissen et al., 2015; Gabínio et al., 2018; Luutonen et al., 2013; Turner et al., 2019). Moreover, recent studies suggest that depending on the type of abuse suffered in childhood, some symptoms may be given priority over others in psychotic disorder, possibly affecting the very phenomenology of the disorder (Isvoranu et al., 2017; Klarić & Lovrić, 2018) and the content of the hallucinations experienced (Peach et al., 2020). Such an association between child abuse and psychosis is not exclusive to this disorder, but any type of adverse event or trauma in childhood can trigger a wide variety of psychopathologies in the adult (Brustenghi et al., 2019; Kaczmarczyk, Wingenfeld, Kuehl, Otte, & Hinkelmann, 2018; Lotzin, Grundmann, Hiller, Pawils, & Schäfer, 2019; Wang et al., 2020).

In studies based on quantitative methodologies, up to 80% of persons diagnosed with psychosis report having suffered one or more traumatic events during

childhood (including sexual abuse, other types of abuse or interpersonal loss) (Turner et al., 2019).

Furthermore, the experience is considered extremely important. Recent qualitative studies, too, have described the situations of persons who have associated traumatic and/or painful events with a psychotic crisis currently being experienced (Wood, Williams, Billings, & Johnson, 2019). It has even been proposed, in line with the stress-vulnerability model of schizophrenia (Zubin & Spring, 1977), that childhood trauma and recent stressful events may have a synergistic effect on cognitive decline and provoke a psychotic episode (Ayesa-Arriola et al., 2020). Research has also shown that persons with psychosis and a history of childhood abuse have poorer psychosocial outcomes, presenting greater difficulty in social functioning, employment and maintaining a home (Klarić & Lovrić, 2018; Turner et al., 2019). In this respect, Domen et al. (2019) reported that over time childhood trauma exposure decreased white matter integrity in patients with psychotic disorder, as may occur with other factors such as cannabis exposure, which may compromise connectivity over the course of the illness. Such a development would account for the poorer health outcomes observed. In this study, a striking observation was that the participants, in interviews and focus groups, alluded to this connection between trauma and psychosis, in different ways and in different contexts, and emphasized these experiences in their discourse. This finding indicates that, subjectively at least, the issue is very important to those affected by it, and that they strongly perceive a connection between the two events. Traumatic events can rupture an individual's life experience, affecting both internal psychological functioning and social activities (Auxéméry, 2018) and persons with psychotic disorders may perceive this trauma as lying at the root of their condition.

If, as the literature suggests, exposure to childhood trauma can have serious psychiatric consequences, careful attention should be paid to detecting children at risk, in violent environments, seeking to prevent their exposure to traumatic situations and intervening to minimize the impact of what has already been experienced. Success in this endeavour would greatly benefit such children's present and future mental health.

In view of the high prevalence of PTSD symptoms among patients diagnosed with psychosis (Rodrigues & Anderson, 2017; Turner et al., 2019), clinical guidelines recommend systematic evaluation of the possible presence of PTSD among persons diagnosed with psychotic disorders, and their treatment in accordance with the recommendations for PTSD (García-Herrera Pérez Bryan et al., 2019; Taylor & Perera, 2015). However, most of the randomized controlled trials that have been undertaken to determine the effectiveness of psychological interventions for PTSD have applied the diagnosis of psychotic disorder or

schizophrenia as an exclusion criterion, while even in the studies that include patients with these conditions, they represent no more than 10% of the study sample (Belsher et al., 2019), and so there is no certainty that the treatments considered achieve the same efficacy in this population. In consequence, there is an urgent need for studies to analyse the treatment of PTSD in persons diagnosed with psychotic disorders, and to determine the usefulness of interventions addressing symptomatic, psychotic and post-traumatic stress modalities. In this respect, Folk et al. (2019) suggested an approach to treating PTSD symptoms in the context of early psychosis care. These authors suggested that individuals with comorbid psychoses and post-traumatic stress symptoms can be appropriately and safely treated with 'Trauma-Integrated Cognitive Behavioural Therapy for Psychosis' (Folk et al., 2019).

The second main area addressed in the present study is that of how hospitalization may constitute a traumatic experience. Specifically, the participants described their perceptions of reification by the health institution and its personnel during the hospital stay, describing a non-person-centred care in which individual needs were not considered.

Our content analysis also highlights the fact that, on many occasions, and especially during involuntary hospital admission, no request is made for informed consent to the procedures performed during hospitalization. The participants in our study believed they lacked control and freedom of choice, in some cases even perceiving their treatment as inhumane, as has also been described in previous research (Tingleff, Bradley, Gildberg, Munksgaard, & Hounsgaard, 2017).

Other studies have also referred to the traumatic nature of some users' experience of psychiatric hospitalization (Tingleff et al., 2017; Wood et al., 2019). Thus, in some samples, 69% of the participants perceived at least one hospitalization event as being traumatic or extremely distressing, with such perceptions being more common among women than men (Paksarian et al., 2014). Patients often believe the psychiatric environment itself to be unsettling and noisy and they consider the information provided during hospital admission is insufficient and untrustworthy, especially with regard to the reasons for and the characteristics of the coercive measures applied, and the medication prescribed (Tingleff et al., 2017). Especially in the case of involuntary admissions, the admission process often generates confusion, leaving the patient with hazy memories of the procedure. Both patients and staff have highlighted the existence of rigid, restrictive care protocols, based primarily on pharmacological treatment and often failing to obtain informed consent (Wood et al., 2019). Recent studies have indicated that clinical practices that make it easier for people to feel they have real freedom of choice and for them to feel safe and at ease would

greatly improve the user experience during involuntary hospitalization (Valenti, Giacco, Katasakou, & Priebe, 2014). Moreover, when the use of seclusion or restraint is unavoidable, patients have expressed their wish for a healthcare professional to accompany them and to show respect and empathy, providing physical and psychological comfort during and after coercion (Tingleff et al., 2017).

The results of the present study illustrate the perceptions of persons in a psychotic state when they are subjected to involuntary psychiatric admission, revealing that in many cases they do not receive explanations about the procedure in terms that are understandable to them. Moreover, many of these patients are not asked to consent to the interventions performed. These results highlight a reality that is often overshadowed by the circumstances of this type of hospital admission. Moreover, at the time of the present study, all participants were free of psychotic symptoms and their discourse was coherent and, in many cases, coincident. This discourse and its critical analysis suggests there is a need for social change, awareness of risk and engagement in risk reduction (Charmaz, 2008; Gonsalves, McGannon, & Pegoraro, 2019).

This study presents certain limitations that should be acknowledged. Firstly, there may have been some self-selection bias in that the analysis only considered the patients who agreed to participate in the focus groups. Those who refused the invitation or who failed to attend may have had different experiences regarding their illness and health care. This decision might have been influenced by the severity of their symptoms when they were invited to participate, or by dissatisfaction with the healthcare received, as users with a poor impression of user-clinician relationships are usually less willing to engage (Grundy et al., 2016). Another limitation is that all the participants were being treated in the same health district, which may compromise the generality of the results we report. Finally, the association between trauma and psychosis was analysed as a secondary consideration to the more general objectives of this study, which limited the time available to study this topic in detail.

5. Conclusions

From the users' perspective, healthcare providers should seek informed consent (or at least provide information in terms understandable to those involved, according to their status) during involuntary hospitalization, in order to alleviate the experience and to minimize the emotional impact of such an event. The awareness, understanding and treatment of trauma (historic, recent or admission-related) should form part of the approach taken to persons with

psychotic disorders, in all care settings. However, to our knowledge, no interventions have been shown to be effective in this regard, and so further research, based on an appropriate study design, is still needed.

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Data availability statement

The data that support the findings of this study are available in the repository of the University of Malaga, RIUMA, at the link [10.24310/riuma.20673](https://doi.org/10.24310/riuma.20673).

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Appendix. Guide used in focal groups and individual interviews

- * When were you diagnosed and how old were you?
- * When did you seek help from the public health system and who did you contact? (describe this first contact, please). What help did you have to access the health services? If you

did not seek help personally, explain how you managed to access the services.

* What possible treatments did they propose to you at the beginning? Did you reach an agreement with the healthcare provider on how to deal with the disorder?

* What treatment did you receive? Describe the drug treatment and psychological therapies provided.

* Was the treatment helpful? Describe what worked and what didn't.

* Did you attend a support or therapy group? Was it helpful?

* Did you require any hospital admission? Describe what it was like, both the positive and the negative aspects.

* How would you describe your relationship with healthcare providers (family doctor, psychiatrist, psychologist, nurse, etc.)?

* Did your family and friends help and support you?

* In addition to the public health system, are you receiving health care elsewhere to help you with psychotic disorder, for example, private treatment? If so, describe what worked and what didn't for you.

* How has the disorder changed over time?

* How do you feel now?

* How does psychosis affect your daily life (studies, work, relationships) and the lives of those close to you?

* What strategies do you currently use to cope with the difficulties generated by the disorder?