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Professional Opinions of Effective Interventions for Adults with Psychotic Disorders Who Experienced Childhood Trauma

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University - University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

This is a qualitative research study that examined professionals' perceptions of effective interventions for adults with psychotic disorders who have experienced childhood trauma. The participants of the study were obtained through a snowball technique. The first participant's information was given to the researcher through the research committee. The researcher then asked every participant to provide the contact information of another professional who fit the research criteria. In total, there were six professionals who were either clinical social workers, clinical psychologists or licensed marriage and family therapists. The data was obtained through structured, in person interviews with each of these professionals. The overall finding of the research was that there is no difference in the effectiveness of interventions for adults with psychotic disorders who have experienced childhood trauma versus those who have not. However, there were many themes found from the research study regarding working with adults who have psychotic disorders including: there is a relationship between childhood trauma and psychosis, there are some interventions that are more effective than others, there are some interventions that are less effective, antipsychotics are helpful, psychoeducation is necessary, normalization and stigma recognition are important and cognitive remediation therapy is great, but unavailable. Additionally, implications for the social work profession and social work education are discussed including the need for more education about psychosis, etc.

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Table of Contents

Abstract	1
Acknowledgments	2
Introduction	4
Literature Review	7
Conceptual Framework	18
Methods	20
Findings	24
Discussion	36
References	46
Appendix A (Email)	50
Appendix B (Informed Consent)	51
Appendix C (Interview Questions)	55

There have been copious amounts of research done on the relationship between childhood trauma and psychotic disorders. Whether it be abuse of any kind or experiencing a natural disaster, all could potentially lead to psychotic symptoms in adulthood. In the following study, the relationship between childhood trauma and psychotic disorders in adults was analyzed. Once the relationship between the two was established, the researcher delved into different interventions that are used for people with psychotic disorders. Finally, the researcher conducted a qualitative study analyzing professional's opinions of those interventions.

There are many different types of trauma that someone may experience throughout their childhood. The most common type of childhood trauma is neglect, where a caregiver does not provide for the child either physically or emotionally, leaving the child to fend for themselves in many situations (SAMHSA, 2016; U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families & Children's Bureau, 2015). In addition to this, many children report having been physically, sexually or emotionally abused throughout their childhood (National Children's Alliance, 2015; SAMHSA, 2016; U.S. Department of Health & Human Services et al., 2015; Finkelhor, Turner, Shattuck & Hamby, 2013). Preverbal trauma is another type of trauma that is prevalent in the United States today, this type of trauma involves any traumatic experience that is experienced by a child who is between the ages of zero and two (Zero to Six Collaborative Group & National Traumatic Stress Network, 2010). Though neglect and abuse are the most common forms of childhood trauma, it can take many other forms such as loss of a parent or sibling, witnessing domestic violence, being bullied or living through a natural disaster (SAMHSA, 2016). Childhood trauma in the forms of abuse and neglect are very prevalent in the United States, with a number totaling over 300,000 in 2015 (U.S. Department of Health & Human Services et al.,

2015). Of the children experiencing these traumas, the children who were the most susceptible were not even a full year old yet (U.S. Department of Health & Human Services et al., 2015). This is a devastating number that could lead to lifelong complications for these children including mental health symptoms.

These traumatic experiences, whether they happen during childhood or not can have a long-lasting effect on a person's brain. Bremner (2006) emphasized the fact that trauma affects both structure and function of the brain. He describes how in response to stress, the amygdala, hippocampus and prefrontal cortex shift and become more vulnerable to stressful experiences (Bremner, 2006). In addition to this, the cortisol and norepinephrine levels within the brain can shift drastically, creating problems with memory (Bremner, 2006). The fact that there are so many physical and chemical changes in response to stress may be related to why people have long lasting effects after a traumatic experience.

Mental health is currently a big topic in the United States as people continue to be diagnosed and treated for these issues. One area of mental health that has been getting a lot of attention is psychotic disorders (NAMI, 2017). There are many different psychotic disorders such as Brief Psychotic Disorder, Schizophreniform Disorder and Schizophrenia, which is the most common psychotic disorder diagnosed (NAMI, 2017). Psychosis is the most prevalent symptom among people with psychotic disorders, causing the person to not be able to determine what is real or fake (NAMI, 2017). During the state of psychosis, people may experience hallucinations, delusions, jumbled thoughts, behavior changes and/or incoherent speech (NAMI, 2017). Because Schizophrenia is the most commonly diagnosed psychotic disorder, it was the disorder that was primarily focused on throughout the study.

According to the National Institute of Mental Health (2017) and the National Alliance on Mental Illness (2015), about 1% of the population in the United States is living with Schizophrenia, the most common diagnosed form of psychotic disorder. Schizophrenia is often associated with three different types of symptoms that are labeled as positive, negative or cognitive (NAMI, 2017). Positive symptoms include things such as hallucinations, where the person either hears, smells, sees, tastes or feels something that is not actually there, and delusions, which are intense beliefs that are not true (NAMI, 2017). Negative symptoms are when something is lost by the person who is experiencing psychosis, such as speaking or being able to feel pleasure (NAMI, 2017). Lastly, cognitive symptoms are symptoms that interfere with a person's cognitive process, such as being able to pay attention or focus (NAMI, 2017).

With the rates of childhood trauma being so high in the United States, the aim of the current study was to examine the relationship between childhood trauma and psychotic disorders and to examine professional opinions about the effects of childhood trauma. This study also examined different interventions for psychotic disorders and gained professional opinions about the effectiveness of these interventions. In the next section, the researcher will present literature connecting childhood trauma and psychotic disorders, as well as, information about current intervention strategies used with this population.

Literature Review

Relationship Between Childhood Trauma and Psychotic Disorders

Adverse Childhood Experiences (ACEs) include many forms of childhood trauma or stressful events such as abuse, neglect or different household stressors (SAMHSA, 2017). These traumatic events often become detrimental to a person's lifespan development (CDC, 2016). While the type of trauma experienced can be significant, it seems as if the number of traumas or stressors experienced is more impactful (CDC, 2016). These traumatic experiences can lead to many health problems across the lifespan, including an early death (CDC, 2016). This is consistent with the relationship between childhood trauma and psychotic disorders that has been getting a lot of attention lately. People who have been diagnosed with a psychotic disorder or are experiencing psychosis are significantly more likely to have experienced trauma during their childhood than their healthy counterparts (Evans, Reid, Preston, Palmier-Claus & Sellwood, 2015; Baudin, Szoke, Richard, Pelissolo, Leboyer, Schurhoff, 2017; Heins, Simons, Lataster, Pfeifer, Versmissen, Lardinois, Marcelis, Delespaul, Krabbendam, Van Os, Myin-Germeys, 2011; García, Montalvo, Creus, Cabezas, Sole, Algora, Moreno, Gutiérrez-Zotes, Labad, 2016; Van Nierop, Van Os, Gunther, Van Zelst, De Graaf, Ten Have, Van Dorsselaer, Bak, Myin-Germeys, Van Winkel, 2013; Veling, Counotte, Pot Kolder, Van Os, Van Der Gaag, 2016; Kilcommons & Morrison, 2005; Reeder, Husain, Rhouma, Haddad, Munshi, Naeem, Khachatryan, Chaudhry, 2017). This suggests that there is a relationship between childhood trauma and psychotic disorders that must be further examined.

Stress. Even the smallest daily stressors can be impactful for adults with a psychotic disorder that have experienced childhood trauma as their stress levels become easily heightened, making them more sensitive to various stressors (Reininghaus, Gayer-Anderson, Valmaggia,

Kempton, Calem, Onyejiaka, Hubbard, Dazzan, Beards, Fisher, Mills, McGuire, Craig, Garety, Van Os, Murray, Wykes, Myin-Germeys & Morgan, 2016; Veling et al., 2016; Lardinois, Lataster, Mengelers, Van Os & Myin-Germeys, 2010). This suggests that the traumatic experiences that these people had as children stick with them into their adulthood and have negative implications. Sexual abuse during childhood increases this heightened stress sensitivity risk, causing adults with psychotic disorders to exhibit more severe psychotic symptoms in times of high stress (Reininghaus et al., 2016). In comparison, those that have experienced childhood sexual abuse but did not develop a psychotic disorder in adulthood have an easier time overcoming stressors (Reininghaus, et al., 2016). This could be because they may have developed resiliency at some point in their lives. This comparison suggests that the relationships between childhood sexual abuse and stress sensitivity could be a result of someone developing a psychotic disorder in adulthood.

In addition to this, when adults with psychotic disorders are exposed to environmental stress, even if it is virtually presented, they have heightened psychotic symptoms (Veling et al., 2016). The certain psychotic symptoms include things such as increased paranoia, a common symptom for those experiencing psychosis (Veling et al., 2016). This could mean that childhood trauma has a significant impact on someone's ability to self-regulate and feel comfortable in social situations.

Mediators. Another common theme among the relationship between childhood trauma and adults with psychotic disorders is that there are many things that can bring about this relationship, which is a process known as mediating. One of the things that mediates this relationship revolves around social situations, where someone feels either supported or defeated (Baudin et al., 2017; Van Nierop et al., 2013). Social support can protect against someone

developing a psychotic disorder, even if they had been traumatized during childhood (Baudin et al., 2017). On the other hand, if someone who has been traumatized in childhood also experiences social defeat, it can make them feel unwelcome and decrease their emotional regulation, putting them at risk of developing a psychotic disorder (Van Nierop et al., 2013). In a study done by Van Nierop et al. (2013) they state,

This suggests a developmental pathway, in which Childhood Trauma may lead to feelings of social defeat, which in turn may result in affective dysregulation and psychotic symptoms in the general population (p.473).

This suggests that there is a process that leads from being traumatized in childhood to developing a psychotic disorder as an adult. This further suggests that inclusive, supportive environments may be necessary to stop this linkage between childhood trauma and psychotic disorders in adults.

Additionally, dissociation and self-concept are two other factors that mediate the relationship between childhood trauma and psychotic disorders in adults (Evans et al., 2015) For dissociation, physical neglect is the only type of trauma that makes it act as a mediator; while low self-concept clarity mediated this relationship in all instances of childhood trauma (Evans et al., 2015). This proposes that there is an internal process that involves one's perception of self that can lead to having a psychotic disorder in adulthood after being traumatized in childhood.

Hallucinations. In addition to the other themes found, there is also a theme surrounding hallucinations. Hallucinations are symptoms that are very prominent and severe in adults with psychotic disorders that experienced childhood trauma (Daalman, Diederens, Derks, Van Lutterveld, Kahn & Sommer, 2012; Misiak, Moustafa, Kiejna & Frydecka, 2016; Solesvik, Joa, Larsen, Langeveld, Johannessen, Bjornestad, Goril, Anada, Gisselgard, Velden Hegelstad &

Bronnick, 2016; Kilcommons & Morrison, 2005). This suggests that experiencing childhood trauma could be connected to the severity of the hallucinations that people with psychotic disorders may experience. Interestingly, enough, one does not have to have a psychotic disorder to experience auditory verbal hallucinations (AVH) so comparing the two groups is unique (Daalman et al., 2012). Childhood trauma catalyzes all types of voices found in auditory verbal hallucinations, whether they be positive or negative in both adults with and without psychotic disorders (Daalman et al., 2012). This suggests that AVH may be independently related to childhood trauma, whether a psychotic disorder is present or not.

The content and demeanor of the auditory verbal hallucinations is significantly related to someone experiencing trauma as a child (Misiak et al., 2016). People with a psychotic disorder who experienced childhood trauma are likely to have third person voices that are negative and offensive, with vulgar content (Misiak et al., 2016). In addition to this, sexual abuse is the most significant type of trauma that leads to developing these harsh auditory verbal hallucinations (Misiak et al., 2016; Kilcommons & Morrison, 2005; Daalman et al., 2012). This insinuates that sexual abuse may result in more intense, long lasting effects on a person, especially if they go on to be diagnosed with a psychotic disorder in adulthood. It also suggests that sexual abuse may fuel auditory verbal hallucinations by providing them with content.

Dissociative symptoms. Dissociation is another theme that is prevalent among the relationship between childhood trauma and psychotic disorders in adults. According to Better Health Channel (2017), dissociation is, “a mental process where a person disconnects from their thoughts, feelings, memories or sense of identity” (p.1). These symptoms are likely to be present in people who have a psychotic disorder and have experienced childhood trauma (Evans et al., 2015; Braehler, Valiquette, Holowka, Malla, Joober, Ciampi, Pawliuk & King, 2013;

Kilcommons & Morrison, 2005). This conveys that children who have experienced trauma may use dissociation as a defense mechanism to protect themselves from the trauma. In addition to this, dissociation is significantly connected to hallucinations in adults with psychotic disorders in the way that it makes a person more likely to experience a variation of hallucinations (Kilcommons & Morrison, 2005). This implies that hallucinations may be triggered by a person with a psychotic disorder dissociating from themselves.

In addition to this, there is a significant connection between emotional abuse, neglect and the total amount of trauma and the severity of dissociative symptoms (Braehler et al., 2013). However, it is not just the type or amount of trauma that matters, the severity of trauma also is connected to severity of dissociative symptoms (Braehler et al., 2013). Collectively, these results indicate that the severity of dissociative symptoms may depend on the type and severity of trauma that was experienced during childhood exclusively.

Functional outcomes. Functionality of adults with psychotic disorders who have experienced childhood trauma is another thing that continues to be assessed (Van Nierop, Bak, De Graaf, Ten Have, Van Dorsselaer, Genetic Risk and Outcome of Psychosis (Group) Investigators & Van Winkel, 2016). To assess for functionality, various common aspects of adulthood such as having a job and being in a relationship have to be taken into consideration (Van Nierop et al., 2016). When these things are taken into consideration, adults with psychotic disorders who have experienced childhood trauma are overall less functional than people who have mood or anxiety disorders who had also experienced childhood trauma (Van Nierop et al., 2016). This implies that there is a specific connection between psychotic disorders and functionality. This also suggests that it is harder for adults with psychotic disorders to function at an expected level, while it may be easier for people with less severe types of mental illness.

Interventions Used

There are many different interventions used for the treatment of psychotic disorders in adults. These can range from at home therapies to intensive treatment programs or even medication treatments. Some of the more popular interventions include: antipsychotics, psychoeducation and cognitive remediation therapy. It is important to note that many treatments overlap and can be used at the same time.

With organizations using these many different kinds of treatments, many use Trauma Informed Care to address their clients' needs (SAMHSA, 2015). When an organization uses Trauma Informed Care, the professionals within the organization can recognize trauma and adequately address it (SAMHSA, 2015). The professionals address the trauma in a way that helps the person move on and avoids retraumatizing them (SAMHSA, 2015). Overall, the main goal of Trauma Informed Care is to address trauma and the negative things that came out of it while helping the client heal (SAMHSA, 2015). Due to the fact that Trauma Informed Care is becoming more popular, many organizations may be adopting this practice in addition to their other methods if they have not already done so.

Antipsychotics. Antipsychotics are one of the most common treatment methods for psychotic disorders because it helps subside major symptoms such as hallucinations and delusions (NAMI, 2017). There are two different classes of antipsychotics: the first generation, which tend to be older ones that have a higher risk for side effects and the second generation, which are newer drugs with less risk of side effects (NAMI, 2017). I decided to include a little bit about antipsychotics because they are a treatment method that is very common. However, most of the literature that I found focused more on therapy and education methods that may be effective in tandem with antipsychotics.

Psychoeducation. Psychoeducation is a treatment that is also commonly used for people who have psychotic disorders (NAMI, 2017). The aim of this intervention is to provide clients and families information about psychotic disorders while offering them support from people going through similar circumstances (NAMI, 2017). These psychoeducation classes last for several weeks, allowing people to bond with their peers (NAMI, 2017) This also gives individuals the opportunity to become more aware of their illness and what they can do to minimize the risk of relapse (NAMI, 2017).

The effectiveness of psychoeducation for psychotic disorders is something that was assessed effectively by the researcher. Psychoeducation classes have a wide range of benefits for the individuals with psychotic disorders that participate in them (Reichart, Pitschel-Walz, Kissling, Bauml, Schuster & Rummel-Kluge, 2010; Chien & Lee, 2013; Chien, Bressington, & Karatzias, 2017; Bechdolf, Knost, Nelson, Schneider, Veith, Yung & Pukrop, 2010). In fact, psychoeducation yields better results than Cognitive Behavioral Therapy in the way that psychoeducation groups often result in better overall quality of life for its participants (Bechdolf et al., 2010). This suggests that the knowledge and understanding which a psychoeducation group offers, gives individuals with psychotic disorders a better self-awareness that makes them feel better than just retraining their brain and cognitive processes. In addition to psychoeducation being helpful to adults with psychotic disorder, it is also helpful to families (Jewell, Downing & McFarlane, 2009). The psychoeducation classes benefit families in the way that it gives them peer support and the skills to help them deal with their family member's illness (Jewell, Downing & McFarlane, 2009). The fact that family benefits are in line with individual benefits suggests that psychoeducation is beneficial for the entire family of someone with a psychotic

disorder. This also indicates that psychoeducation classes may bring the family closer together because of the newfound understanding of the illness.

Mindfulness-Based Psychoeducation Programs are something that have been growing more popular in this line of intervention. Individuals with psychotic disorders who participate in this kind of psychoeducation are less likely to have a return of symptoms for a longer period than other types of psychoeducation (Chien & Lee, 2013; Chien et al., 2017). This suggests that mindfulness practices may add something important to a psychoeducation group, such as teaching people how to focus on the present. It also may be indicative of the fact that mindfulness may have to be added to generic psychoeducation groups to improve results for the individuals with psychotic disorders.

Additionally, neurocognitive functioning of adults with psychotic disorders is something that can determine the effectiveness of psychoeducation programs (Jahn, Pitschel-Walz, Gsottschneider, Frobose, Kraemer & Bauml, 2011). Neurocognitive functioning is positively correlated with the amount of information a person with a psychotic disorder retains after a psychoeducation class (Jahn et al., 2011). This suggests that if someone with a psychotic disorder has a lower cognitive functioning before entering a psychoeducation program, they may need extra support and guidance in order to retain the information given to them.

Cognitive remediation therapy. Cognitive Remediation Therapy (CRT) is another form of therapy frequently used for people with psychotic disorders (NAMI, 2017). According to NAMI (2017), CRT is, “training designed to address attention and thinking problems experienced with schizophrenia and other psychotic disorders” (p. 16). This means that CRT attempts to get the brain to use cognition normally. In addition to this, this therapy helps retrain the brain on how to focus and process information (NAMI, 2017). CRT is typically an electronic

game played on the computer, where the game gets increasingly difficult as the person playing gets better (NAMI, 2017). Lastly, CRT can be included in someone's treatment plan, but, otherwise, people can independently purchase it online and progress at their own pace (NAMI, 2017).

There has been a lot of research done on the effectiveness of Cognitive Remediation Therapy (CRT) for people living who have psychotic disorders. CRT is an effective treatment method for adults with psychotic disorders, helping them in many different aspects of their cognition, as compared to other forms of treatment (Penades, Pujol, Catalan, Massana, Rametti, Garcia-Rizo, Bargallo, Gasto, Bernardo & Junque, 2013; Lee, Redoblado-Hodge, Naismith, Hermens, Porter & Hickie, 2012; Mendella, Burton, Tasca, Roy, Louis & Twamley, 2015; Hargreaves, Dillon, Anderson-Schmidt, Corvin, Fitzmaurice, Castorina, Robertson & Donahoe, 2015; Davidson, Johannesen & Fiszdon, 2016; Lindenmayer, Fregenti, Kang, Ozog, Ljuri, Khan, Goldring & McGurk, 2017; Bosia, Buonocore, Bechi, Spangaro, Pigoni, Croci, Cocchi, Guglielmino, Bianchi, Smeraldi & Cavallaro, 2016; Corbera, Wexler, Poltorak, Thime & Kurtz, 2017; Tan, Zou, Wykes, Reeder, Zhu, Yang, Zhao, Tan, Fan & Zhou, 2016). This suggests that this may be a method that should be expanded and universally used for treatment of psychotic disorders.

In addition to CRT being effective, it is also connected to different aspects of social functioning (Lindenmayer et al., 2017). In fact, adults with psychotic disorders are likely to have increased social functioning after partaking in CRT if they initially had less severe symptoms (Lindenmayer et al., 2017). Specifically, this means that people who completed this treatment and had less severe symptoms coming into it were more likely to have improved relationships, behaviors, etc. (Lindenmayer et al., 2017). This suggests that CRT may be more effective if

psychotic symptoms are decreased and more controlled before starting CRT. It also suggests that if someone with a psychotic disorder is really struggling with relationships and social functioning, CRT should be a part of their treatment plan or at least offered to them.

Additionally, CRT is associated with different kinds of memory being improved for adults with psychotic disorders (Lee et al., 2012; Hagreaves et al., 2015; Davidson et al., 2016; Lindenmayer et al., 2017; Corbera et al., 2017). Specifically, working and verbal memory are likely to significantly increase in functioning after an adult with a psychotic disorder underwent CRT (Davidson et al., 2016; Corbera et al., 2017). This suggests that the game element of CRT assists adults with psychotic disorders in processing language and things around them in the short-term. In addition to verbal and working memory, visual memory is something that is also stimulated by CRT, predicting enhanced social functioning among adults with psychotic disorders (Lindenmayer et al., 2017). Collectively, this indicates that CRT may stimulate the brain enough to assist those with psychotic disorders in multiple different parts of the brain, potentially improving their whole memory.

Finally, the learning potential of adults with psychotic disorders and CRT are related in some way (Davidson et al., 2016). In particular, learning potential, which is the ability to learn, reason, and solve problems, is related to CRT in the way that it helps adults with psychotic disorders be able to tap into their potential (Davidson et al., 2016). This suggests that CRT bridges a gap between one's learning potential and the realization of this potential. In addition to this, learning potential is also associated with a greater likelihood of developing skills through CRT for adults with psychotic disorders (Davidson et al., 2016). This, in particular, suggests that learning potential may be a predictor of whether someone will have the ability to develop and use the skills that CRT attempts to teach them.

Illness Management & Recovery. Illness Management & Recovery (IMR) is an evidence based practice that is used with people who are experiencing a severe mental illness (The Bridge, 2017). This type of treatment can either be done in a group or an individual setting and focuses on helping the client work toward their personal recovery goals (The Bridge, 2017). In addition to this, IMR focuses on teaching people about their illness and equipping them with knowledge to address their issues and work toward recovery (The Bridge, 2017). IMR also focuses on using incorporating support systems that clients already have and strengthening them through education (The Bridge, 2017). Though this is a treatment that specifically serves clients with severe and persistent mental illness, the researcher decided to focus on the three aforementioned interventions for this research. The researcher made this decision because IMR is very popular and the other treatment methods are less spoken about.

Conceptual Framework

With the following research study, the researcher adopted the concepts about psychoeducation and normalization for people with psychotic disorders laid out by Kingdon and Turkington. Kingdon and Turkington (2005) emphasized the importance of psychoeducation, especially for those that have a psychotic disorder and their families because they are disorders that are stigmatized at high rates. In their book, Kingdon and Turkington (2005) discuss how when psychoeducation is individualized, people likely get more out of it. This is because they are given the opportunity to discuss their own symptoms and obtain a better understanding of their illness, while getting feedback from a professional (Kingdon & Turkington, 2005). Having this understanding of psychoeducation provided a place of reference when obtaining professionals opinions about psychoeducation as an intervention for psychotic disorders.

Normalization

Kingdon and Turkington (2005) suggest that adding the normalization of psychosis into psychoeducation is beneficial for people with psychotic disorders. They described normalization as a,

Process by which thoughts, behaviors, moods, and experiences are compared and understood in terms of similar thoughts, behaviors, moods and experiences attributed to other individuals who are not diagnosed as ill - especially mentally ill (Kingdon & Turkington, 2005, p. 87).

They suggest that normalization has a goal of lowering stigma, isolation, and fear while helping to heighten self-esteem (Kingdon & Turkington, 2005). Stigma is huge for people with mental illness, especially those with psychotic disorders because they are often seen as untreatable (Kingdon & Turkington, 2005). Recognizing that they are not their illness may help these people

to better cope with their illness and be more receptive to other treatments. Kingdon and Turkington (2005) warn that a professional must be very careful to not minimize the illness, yet normalize it, which can be tricky. Minimizing the illness could lead to the individual feeling like they do not have a problem and that they do not need treatment (Kingdon & Turkington, 2005). This concept was discussed with the professionals interviewed for the study in order to see if they agreed or disagreed with Kingdon and Turkington's views.

Methods

Design/ Methodology

For this study, a qualitative design was used by conducting interviews with professionals who work with people that have psychotic disorders. This research design was chosen because of the need to obtain concrete examples of when certain interventions worked or failed for the individual being interviewed. Overall, the design facilitated the answering of the research question: What are professional perceptions of effective interventions for adults with psychotic disorders who experienced childhood trauma?

Sampling

In order to obtain the information needed, the researcher interviewed six different professionals in the twin cities that work with adults who have psychotic disorders. These professionals included individuals who are licensed to provide therapy to people with psychotic disorders including social workers, psychologists, and marriage and family therapists. The researcher only interviewed professionals that had at least a Bachelor's degree and were either Licensed Social Workers or Licensed Psychotherapists. The researcher decided to only obtain the opinions of these professionals because they have the experience working with adults who have psychotic disorders. To obtain the first two subjects, the researcher asked for suggestions from committee members, Rebecca Sorenson and Samantha Simon. The researcher then asked the two first subjects for suggestions for more subjects and continued to build the sample this way, utilizing a snowball technique (Grinell, Williams & Unrau, 2016). The researcher continued this method of obtaining a sample until six professionals were interviewed. This method was used by the researcher because it allowed for a variety of people and it was somewhat convenient.

Protection of Human Subjects

Before conducting any actual research, the researcher gained approval from the St. Catherine University Institutional Review Board to assure that all intended methods were safe and that no harm would be done to the participants. Additionally, in order to protect the subjects being interviewed about their experiences, the researcher first sent them an email to ensure that they were willing and able to participate in the study (Appendix A). The initial email informed them about the study and what it would be used for so that they knew exactly what they were agreeing to. In this email, they were also informed that their identities would be kept totally confidential. If the potential subject agreed to participate in the study, the researcher responded, asking them to offer a few different times that would work for the interview to take place.

Once a time was set for the interview, the researcher sent a follow up email that contained a consent form (Appendix B) and a list of questions that the participant was asked to answer (Appendix C). The informed consent form included information about the study, why they were chosen to participate, and how any information obtained in the interview would be used. It also informed them that they could choose to not participate at any time throughout the process. This form was then reviewed before the interview took place, to ensure that both the participant and researcher were on the same page. After the interview was complete, all materials from it were kept in a secure, locked location that only the researcher had access to. The materials obtained will all be effectively disposed of no later than June 20, 2018.

Data Collection Instrument and Process

To obtain the information needed for this study, the researcher conducted qualitative interviews with approximately six different professionals that work with adults who have psychotic disorders. The interviews took around 60 minutes to complete and were audio-

recorded to ensure consistency throughout the research process. Participants were asked a series of questions related to their experience working with this population (Appendix B). The questions asked revolved around the findings in the literature review and the literature used for the conceptual framework piece.

Data Analysis Plan

Before collecting any data or transcribing it, the researcher obtained a journal and took notes throughout the process in it. This was an important step for analyzing qualitative research because it provided a place of reference for the process that the researcher underwent (Grinnell, Williams & Unrau, 2016). To analyze the data obtained through the interviews, the researcher first listened to each audio recording and transcribed them. During the transcription process, the researcher was sure to document any nonverbal communications that happen during the interview, a technique that was significantly important because it sets the tone of the interview (Grinnell, Williams & Unrau, 2016). Once this step was completed, the researcher read through each of the transcriptions carefully. This allowed the researcher to obtain a feel for what the data said.

Once the transcriptions were completed and had all been read thoroughly, the researcher moved on to coding the data. Coding is a process that includes many different tasks including identifying meaningful parts of the data, grouping the meaningful parts of data, giving each group a code, and organizing the groups (Grinnell, Williams & Unrau, 2016). The first task involved identifying parts of the data that were meaningful by themselves. This could have been anything from a word to a whole section of data and helped in grouping the data for the next task (Grinnell, Williams & Unrau, 2016). The next task involved grouping the meaningful parts of the

data, ensuring that there were not too many pieces in a miscellaneous group (Grinnell, Williams & Unrau, 2016).

Next the researcher moved on to the next section of coding that involved comparing the groups identified and determining if there was a relationship between groups (Grinnell, Williams & Unrau, 2016). These relationships were used to develop overarching themes that the data presents and new codes were given to each theme. These codes were then documented in the margins of each transcription much like previous codes for the groups (Grinnell, Williams & Unrau, 2016).

Once these coding steps were completed, the researcher interpreted the data and assessed whether the results were reliable or not, which was important in presenting the findings (Grinnell, Williams & Unrau, 2016). The researcher ensured reliability of data obtained by proving their personal credibility, showing that the data was dependable and recognizing the researchers own biases (Grinnell, Williams & Unrau, 2016). Proving this reliability allowed people to be more receptive to the data obtained and to trust in the results of the study.

Findings

This study answered the research question: What are professional perceptions of effective interventions for adults with psychotic disorders who experienced childhood trauma? It did this by interviewing a total of six professionals who have experience working with adults who have psychotic disorders and analyzing the data obtained. From the interviews, the following themes were discovered: there is a relationship between childhood trauma and psychosis, there are some interventions that are more effective than others, there are some interventions that are less effective, antipsychotics are helpful, psychoeducation is necessary, normalization and stigma recognition are important and cognitive remediation therapy is great, but unavailable.

Sample

To be eligible to participate in this study, participants had to at least have a Bachelor's degree and be licensed to provide therapy to adults with psychotic disorders. All six participants were women who worked out of either Minneapolis or St. Paul. Of the six participants that were interviewed, two were clinical psychologists, three were clinical social workers and one was a licensed marriage and family therapist. Participant one was a clinical psychologist and considered herself a "schizophrenia specialist", she has been working in the field for 20+ years. Participant two was a clinical social worker and works with people who are having their first episode of psychosis, she has been in the field for 5 years. Participant three was a clinical social worker who works closely with schizophrenia spectrum disorders, she has been in the field for 6 years. Participant four was a clinical psychologist and works with people who have had multiple episodes of psychosis, she has been in the field for 20+ years. Participant five was a licensed marriage and family therapist who specialized in dissociative disorders and childhood trauma, she has been in the field for 13 years. Finally, participant six was a clinical social worker who does individual therapy for those with psychotic disorders, she has been in the field for 10 years.

Due to the fact that they had an array of expertise and experience, themes were easy to come by and it was clear that they were all passionate about working with adults with psychotic disorders.

Correlation and Not Causation Between Childhood Trauma and Psychosis

During the interviews, the participants were asked if they believed there was a relationship between childhood trauma and psychotic disorders in adults. All the participants believed that there was a correlation between the two but not a causation. Additionally, many of the participants agreed that there were specific types of trauma that seemed to impact this correlation more than others and that there were things that differentiated clients who had experienced childhood trauma versus those who had not.

Types of trauma. When the participants were asked if they believed that any specific types of traumas were more significant to this relationship than others, four reported that sexual abuse was the most detrimental. For example, participant three said, “Sexual abuse that happens early on can really affect the person during their psychotic episodes. It can fuel the content of their delusions or hallucinations, which is extremely hard to deal with”. Additionally, participant six, who uses psychodynamic theory, commented on the significance of childhood sexual trauma, especially at a young age. She stated, “If you experience any type of trauma, especially sexual trauma, during the schizoid development, there is a greater likelihood for psychotic type presentation. If it happens this early, it affects how people perceive things and integrate them into their lives”.

Half of the participants also agreed that environmental stressors and trauma during childhood tend to be more significant than other traumas. An example of this from participant five is, “Highly disorganized families, often where one or both parents are alcoholics, unavailable for lots of reasons tend to have a significant impact on psychosis for the adults that I

work with”. In addition to this, participant six touched on the significance of environmental stressors when she said,

Environmental type traumas like financial instability, environmental safety issues, those sorts of traumatic more subculture or cultural, environmental based traumas if those start early on and it's more integrated into the environment, it can cause more fragmentation which then can lead to more psychotic type features.

Differentiation. As part of the interviews, the participants were asked if they could describe a time that they had a client with a psychotic disorder who experienced childhood trauma. All the participants were able to pick out a specific example of a client who met this criterion. The participants were then asked if there was anything that differentiated these clients from those that did not have psychotic disorders. Of all the participants, four reported that the clients who had experienced childhood trauma had heightened emotional reactions to different situations, which differentiated them from other clients. For example, participant two stated, “The trauma was very much unresolved and that effected the emotional responses that she had to just about everything, especially mom. She would get very angry both at herself because of her reactions and at others for their influence on her emotions”. Another quote that supports these findings from participant four when describing her client is, “Her possibility of experience intense emotions or intense psychotic symptoms was higher than other peoples and she was sometimes hard to engage because she was having an emotional response to internal voices ”.

Intervention Effectiveness Differs for Adults

Another thing that the participants were asked during the interviews was what interventions they typically use with their clients and what seems to work best for adults with psychotic disorders. Though there was an agreement among all participants that there were not

interventions that worked better for those who experienced childhood trauma, there were definitely interventions that worked better for working with adults with psychotic disorders in general.

Psychoeducation. When asked about typically interventions used, every participant agreed that psychoeducation was one that was very important for adults with psychotic disorders. This was supported by participant three when she stated, “We educate them on what psychosis is, you know, the stress vulnerability model, you have to know how to take care of yourself right? So, we basically tell them this is how you take care of yourself and educate them on their symptoms so they can do this”. In addition to this, participant five described in detail how crucial psychoeducation is to working with her adult clients who have psychotic disorders. She said, “I use psychoeducation around fragmentation and why it is that they are having certain experiences. I also educate them on their symptoms and normalize them in order to make them feel validated and comfortable”. All the participants emphasized the importance of psychoeducation and stressed that it is also one of the most effective interventions for this population.

Cognitive behavioral therapy. In addition to psychoeducation, five of the six participants reported that they use cognitive behavioral therapy as one of their typical treatment models for adults with psychotic disorders. Participant one stated, “I use CBT for psychosis, which is about helping clients learning to identify their symptoms as symptoms and then have a set of coping skills and using them”. Additionally, participant two reported that cognitive behavioral therapy is one of her main vessels of intervention when she said, “There’s also a lot of opportunities to build resilience and like hope and recovery and so I guess CBT, we do a lot of cognitive restructuring with self-stigmatizing thoughts especially around diagnoses”. Though

these are just two quotes from the six participants, five of them agreed that cognitive behavioral therapy was something that they used regularly. They also agreed that they would consider cognitive behavioral therapy to be one of the more effective interventions.

As part of the interview, the participants were also asked if they believed any interventions were less effective when working with adults who have psychotic disorders who had experienced childhood trauma. All the participants agreed that there were not any interventions that they could think of that were less effective for those with childhood trauma. They did however say that there were less effective interventions when working with adults who have psychotic disorders in general.

Pushing clients. Of the six participants, five of them agreed that pushing clients to talk about or accept things they are not ready for can be harmful to the therapeutic relationship and to the client's overall success. For example, participant three stated, "Attempting to have people accept their diagnosis and trying to get people to accept any sort of what you perceive as reality vs what they perceive. Those are all going to be things that are going to be pretty detrimental to them and to the relationship". In addition to this, participant four also was in agreement that pushing clients is not effective when she said,

Things need to be slowed down a lot of the time. You can't push things, sometimes concepts aren't going to be well understood the first time you explain it. I think that you have to just break things down into small enough chunks and be okay with repeating yourself. If you push the client to understand something, it puts too much pressure on them when they are already dealing with so much.

Finally, participant six also had views and experience that supported these findings when she stated,

When I was trying an intervention that didn't align with the person's perception or their experience of their reality. Um, so when I challenge what they think is true or if someone was saying that they were really uncomfortable with this, but I'm like no this is your reality, they get uncomfortable and often push back.

It is clear that these participants are in agreeance that pushing the client to believe or feel something that they are not ready for is a less effective intervention when working with adults who have psychotic disorders.

Antipsychotics

During the individual interviews, the participants were asked what their opinions were on the use of antipsychotics for adults with psychotic disorders. There was an overall agreeance amongst participants that antipsychotics seemed to be helpful for their clients who had psychotic disorders. Additionally, all the participants were able to describe a specific experience where they had to try and guide a client to consider using an antipsychotic.

Helpfulness. Of the six participants interviewed, all of them agreed that the use of antipsychotics can be very helpful to adults with psychotic disorders, whether they experienced childhood trauma or not. For example, participant two reported,

Well, I do believe that the best, evidence based approach for treatment of psychosis is antipsychotics and therapy together. I have seen some people who did not respond to antipsychotics right away and they had to try many different kinds, which was hard. I believe that clients with psychosis should be on an antipsychotic also because it makes the therapy more effective.

In addition to this, Participant one agreed that antipsychotics were helpful for this population when she said, "I believe that antipsychotics and having a relationship with a psychiatrist is

important for these clients. I think that the first treatment is antipsychotics as well. I can't help people do symptom identification and management if they're florally psychotic all of the time".

Guiding. Professionals who work with adults who have psychotic disorders are often put into a situation where they have to navigate the pros and cons of taking antipsychotics. In the interviews, the participants were asked if they had every had to guide a client who was considering trying an antipsychotic. Every single participant started laughing when they were presented with this question and reported that indeed, they had been in this situation before. An example of this from participant four is when she said,

Some of them are afraid and they feel like it's their choice to take them or not. Some of them have to be told that their choice is slowing them down and that they'd be better off if they tried something. I have to convince a lot of clients that the medications they are prescribed are not poisonous, which is tough because they are scared.

Additionally, participant five reported that they have also had to guide multiple clients who were considering taking antipsychotics, which she described by saying,

When clients decide to stop taking their antipsychotics, I do a lot of reminding them what their functioning level looked like on medications because I've seen it and I know their thinking is clear. I have to remind myself that they hate being psychotic and that a lot of times they come off because they don't want to feel different by taking the medications. This leads me to using a lot of normalization about taking medications.

Though this is only two of the participants quotes, all six of them have had this experience of guiding a client to at least consider taking an antipsychotic.

Psychoeducation

One of the questions that was asked in the interviews was how they participants felt about psychoeducation for adults with psychotic disorders who experienced trauma. All the participants agreed that there was no difference in effectiveness of psychoeducation between adults with psychotic disorders who experienced childhood trauma and those who did not. Though this was the case, they also all agreed that psychoeducation was the foundation of their work with clients who have psychotic disorders because it is important for them to understand their symptoms. Many of the participants also emphasized the importance of incorporating social skills into their curriculum with this population.

Social Skills. As part of this section of the interviews, the participants were asked if they found a particular curriculum to be the most helpful for adults with psychotic disorders. Though they all offered up many things, all of the participants agreed that focusing on social skills as a part of psychoeducation was very helpful for their clients. Participant one noted,

I have a social skills section that includes friends, dating, how to meet new people, all sorts of social skills. This section also includes dealing with difficult people. I believe that having a social skills section is important because often times people who are experiencing psychosis have difficulties with relationships.

Participant three also commented on social skills and why they are so important with the population that she works with when she said,

Social skills are such an important part of the psychoeducation curriculum that I use with clients. Most of my clients are under the age of thirty, so a lot of them want to date and have a goal of having a significant other, which is totally age appropriate. This is one of the biggest reasons that I use this segment in my curriculum because these people want things that everyone their age wants, but they don't have the skills to get there.

These are just two quotes of the many that support the conclusion that social skills are an important part of psychoeducation when working with adults who have psychotic disorders.

Normalization is Regularly Used

As part of the interview process, participants were asked whether they had heard of normalization being used as a technique and if they used this technique with their clients. All six participants confirmed that they knew what this technique was and that they used it regularly with their clients. As part of normalization, stigma is often addressed with clients, especially those who have a diagnosis of a mental illness.

Understanding of stigma. After it was clear that the participants all used normalization, they were asked how they addressed stigma with their clients. Of the six participants, five reported that the way they addressed stigma depended on how their clients understood stigma and how they were experiencing it. For example, participant six stated, “I first get an idea of what their perception is of their experience, how their belief system around their own experience and then their belief system or concerns and thoughts about being around the people they know with their symptoms and being around in the world”. Additionally, participant five’s response supported this when she said,

Just calling out the stigma and asking for experiences where people treat them differently. Or I do a lot of work with people whose family treat them as the ‘sick’ one, which adds a lot of stigma. I get a sense of how they have experienced the stigma and how they understand it and then go from there.

In addition to many of the participants gaging how their clients understand stigma, many of them also focus on how mental illness is portrayed in the media.

Media portrayal of mental illness. When the participants were asked how they address stigma with their clients, there was a lot of talk about how the media portrays mental illness. Four out of the six participants noted that they talk about what has been shown in the media and how they try and help the clients understand that just because they are sick does not mean that they are a bad person. For example, participant one reported,

I talk a lot about the misconception of people who don't have any education. Especially portrayal in the media of serial killers or those are the people who shoot up schools. I always tell my clients that there is a bad apple in every bunch and just because someone has a mental illness does not mean that they are violent or a criminal because a lot of them fear this.

Participant four's response to this question also supports this finding. She reported,

We talk about cultural and media expectations and ads and how typical males and females are seen. We also talk a lot about the idealistic American dream and how we're always supposed to be happy and how that just doesn't fit. These people believe that since they are not the 'typical American' represented in the media that they are destined to be miserable and alone forever, so I challenge that.

Every participant reported that they have to address the stigma of mental illness to their clients. They all reported that most of their clients had a negative view of themselves because of stigma, which is why they focus on it in therapy.

Unavailability of Cognitive Remediation Therapy

During the interviews, the participants were asked how they felt about cognitive remediation therapy being used for adults with psychotic disorders. Two of the participants had

never even heard of this intervention being used. The other four participants had heard of it, but only one had experience with it.

Unavailable. When asked about cognitive remediation therapy, the four participants who had heard of this intervention reported that it was really unavailable. For example, participant one reported,

I think that cognitive remediation therapy can be really helpful, it's just so unavailable. I would love for it to become more available like the computerized stuff. More available and more covered by insurance. Unfortunately, insurance won't cover it because it's too new and they aren't convinced it'll decrease their costs.

Additionally, participant two also emphasized how unavailable cognitive remediation therapy is to clients when she said, "Cognitive remediation therapy is so new, but I have heard a lot of good things about it. It's just really not something that is available to clients. I have only heard of it being available at the U in different studies". All the participants who had heard of cognitive remediation therapy reported that it was not readily available to clients.

Ethical Dilemma. Of the four participants who had heard of cognitive remediation therapy, all of them reported that it was only available through studies at the University of Minnesota. They all agreed that this brought up an ethical dilemma for them because they were never certain if their clients were actually getting the treatment or not. For example, participant three stated, "There's an ethical dilemma there because you don't know whether they are going to get the treatment or not. We just tell them and it's a decision they make for themselves, but it still doesn't feel good". Participant two's response also concurred with this when she said,

In the studies, they give people an Ipad to use and you have to do a certain amount of activities per day. Umm, but there's a control group too so I don't know if the people I've

sent are in the control or not and it's not my role to know. This creates an ethical dilemma for me because I could potentially be sending them to a study that they get nothing out of.

All the participants who had heard of cognitive remediation therapy agreed that there was no difference in effectiveness between adults with psychotic disorders who had experienced trauma and those who had not.

Discussion

The purpose of this study was to examine professionals' opinions of effective interventions for adults with psychotic disorders who experienced childhood trauma. The researcher wanted to determine whether there was a difference in effectiveness of certain interventions for adults with psychotic disorders who experienced childhood trauma versus those who did not. The researcher examined this by using a qualitative study where six professionals were interviewed and asked about their experiences. It was found that among this sample, there was no difference in effectiveness amongst interventions between those clients that experienced childhood trauma and those who did not. Though there was no difference found, the study did gain insight into what interventions work well for working with adults who have psychotic disorders in general. Some of the data obtained from the study were consistent with what the literature reported. Mainly, it was found that there is a correlation between childhood trauma and psychotic disorders in adults, antipsychotics are helpful, psychoeducation is essential and normalizing the experience of clients is important. On the other hand, the findings of the study were divergent from the literature when it came to cognitive remediation therapy.

Because this study was exploratory, it was expected that there may not be any differences in the effectiveness of interventions for those with psychotic disorders who experienced childhood trauma versus those who did not. It was clear that there was a correlation between childhood trauma and psychosis, but that was about it. There were no differences found in the way that a professional would work with these clients. It was found that interventions were consistent whether someone experienced childhood trauma or not. This could be due to the serious nature of psychotic symptoms. Whether there is trauma or not, the clients are still experiencing high symptoms that are scary and have to be addressed.

Correlation Not Causation Between Childhood Trauma and Psychosis

The first theme that was found through the research is that there is a relationship between childhood trauma and psychotic disorders in adults. Though it was clear that there is not a causation relationship, there is definitely a correlation between the two. The participants were all able to think about multiple clients of theirs who had a psychotic disorder and experienced childhood trauma. This theme is consistent with what was found in the literature. The literature found that adults with psychotic disorders have a higher likelihood of experiencing childhood trauma than adults who have not been diagnosed with a psychotic disorder (Evans, Reid, Preston, Palmier-Claus & Sellwood, 2015; Baudin, Szoke, Richard, Pelissolo, Leboyer, Schurhoff, 2017; Heins, Simons, Lataster, Pfeifer, Versmissen, Lardinois, Marcelis, Delespaul, Krabbendam, Van Os, Myin-Germeys, 2011; García, Montalvo, Creus, Cabezas, Sole, Algora, Moreno, Gutiérrez-Zotes, Labad, 2016; Van Nierop, Van Os, Gunther, Van Zelst, De Graaf, Ten Have, Van Dorsselaer, Bak, Myin-Germeys, Van Winkel, 2013; Veling, Counotte, Pot Kolder, Van Os, Van Der Gaag, 2016; Kilcommons & Morrison, 2005; Reeder, Husain, Rhouma, Haddad, Munshi, Naeem, Khachatryan, Chaudhry, 2017). With this correlation being consistently found across the research and the literature, it is clear that there is a relationship between childhood trauma and psychosis.

As part of this theme, the research found that childhood sexual abuse seemed to have the highest impact on adults with psychotic disorders. The participants were not able to pinpoint why this was, but it is consistent with the literature found on this topic. The literature explains sexual abuse during childhood makes people more vulnerable to stress throughout their lives, so when people with psychotic disorders have experienced childhood sexual abuse, their symptoms are

worse during times of stress (Reninghause, et al., 2016). This further supports the correlation that has been found between childhood trauma and psychotic disorders in adults.

In addition to childhood sexual abuse, many of the participants in the study agreed that childhood environmental stress/ trauma impacts adults with psychotic disorders. This is consistent with the literature that was found surrounding this topic. Veling et al (2016) found that adults with psychotic disorders tend to have heightened responses to environmental stimuli if they experienced environmental stress in their childhood, this could include more paranoia and other heightened symptoms. This consistency between the research and the literature could mean that professionals should be screening for things that may be considered an environmental trauma. This could include things like growing up with domestic violence happening in the home, parents who are dismissive and so much more.

Intervention Effectiveness Differs for Adults

More Effective. During the interviews, participants were asked to identify any interventions that they have found to be most effective with their adult clients who have psychotic disorders. Of the six participants interviewed, all of them reported that psychoeducation was an effective part of their work with clients. They all reported that it is the foundation of a lot of the work that they do with clients because it teaches them about their symptoms. These reports are consistent with what the literature says about psychoeducation. The literature says that psychoeducation is often seen as an intervention that is crucial and gives the clients with psychotic disorders a better quality of life than any other treatment (Bechdolf et al., 2017). This agreeance amongst the literature and the research suggests that adults who have psychotic disorders are better off if they get psychoeducation as part of treatment. It also

suggests that being able to learn about their symptoms and figure out how to identify what is going on may be the foundation of the work that these clients need.

The research also found that cognitive behavioral therapy is one of the most effective interventions when working with adults who have psychotic disorders. Five of the six participants interviewed said that this is the primary model of therapy that they use with their clients. Interestingly enough, the one who did not use cognitive behavioral therapy reported that she believed that it was an intervention that was less effective. She said,

I mean cognitive behavioral therapy has its value from my perspective, but not as a primary treatment. It's just not the bulk of what I do. Instead I build relationships with the clients and model healthy attachment, that's what's important.

The participant that said this works primarily with adults who have psychotic disorders that are experiencing more dissociative symptoms. This discrepancy suggests that when a person is having high dissociative symptoms maybe cognitive behavioral therapy is not the best intervention.

Less Effective. When the less effective interventions for adults with psychotic disorders who experienced childhood trauma were examined, the participants were unable to think of interventions that would be less effective because the person had experienced childhood trauma. However, all of the six participants were able to identify interventions that were less effective for adults with psychotic disorders in general. Of the six participants, five reported that pushing clients in any way could result in a damaged therapeutic relationship and a withdrawn client. These could be things such as pushing a client to accept a diagnosis or trying to push them to believe something that is outside of their current reality. This suggests that professionals need to remember to stay with the client and meet them where they are at in order to best help them. It

also suggests that adults with psychotic disorders have a lesser ability to deal with external stress such as pushing from others.

Antipsychotics

Another theme that was found from the research is that antipsychotics are helpful to adults with psychotic disorders. All of the six participants in the study agreed that antipsychotics were important for these clients because it gets them to a place where therapy can be effective, which is consistent with the literature found. The literature says that antipsychotics are a very common method used in the treatment of psychotic disorders because they help lessen the amount and intensity of hallucinations and delusions that a client is experiencing (NAMI, 2017). This triangulation between the literature and research implies that antipsychotics can be very helpful to adults who have psychotic disorders. There was not enough information gathered to determine if there were any differences in the effectiveness of antipsychotics for those with psychotic disorders who experienced childhood trauma versus those who did not.

Psychoeducation

The research also found that psychoeducation is crucial to working with adults who have psychotic disorders, whether they experienced childhood trauma or not. All six of the participants that were interviewed agreed that psychoeducation was the base of their work with clients. They discussed how it is frequently the most effective intervention that they use because it allows clients to understand their symptoms. This is consistent with what the literature found about psychoeducation. The literature reviewed states that psychoeducation can often be more effective than cognitive behavioral therapy because it gives clients a better quality of life (Bechdolf et al., 2010). This consistency suggests that professionals should regularly utilize psychoeducation in their work with clients.

In addition to the participants agreeing that psychoeducation is really helpful to their clients, five of them agreed that having a segment about social skills was important. Many of them reported that this was important because their clients usually have a hard time interacting with people, especially peers. This is consistent with the literature found about psychoeducation. The literature says that psychoeducation has many benefits for the clients because of the wide range of topics that may be covered (Reichart et al., 2010; Chien & Lee, 2013; Chien, Bressington & Karatzias, 2017; Bechdolf et al., 2010). With the fact that there is clearly a lot of professional choice in what topics are covered in psychoeducation, it seems that professionals should include content about social skills. It seems to be an effective intervention that allows clients to learn how to be social with people their own age, something many of them struggle with.

Normalization is Regularly Used

As part of the study, the participants were asked if they knew what normalization was and how they addressed stigma with their clients. All the participants had heard of normalization and used it in practice with their clients who had psychotic disorders. In addition to this, they were asked how they addressed stigma with their clients. The participants all reported that they address stigma in one way or another and that it seems to be important, effective work. This is consistent with the literature found about stigma and normalization. Kingdon & Turkington (2005) reported that normalization helps lower stigma and lowering stigma helps boost clients' self confidence and empowers them. This allows clients to cope with their illness more effectively because it helps them feel less different than their healthy counterparts (Kingdon & Turkington, 2005). This theme suggests that professionals should figure out how to best address stigma with their clients and work this the interventions they use with them.

Cognitive Remediation Therapy

The final theme found from the research is that cognitive remediation therapy is not readily available as a treatment method. When asked about this therapy model, two participants reported that they had never even heard of it before. The other four participants reported that it was only available through studies at the University of Minnesota. They were unaware of its effectiveness because they were not involved in the studies other than suggesting them to their clients. These findings are very different than what was found in the literature about cognitive remediation therapy. The literature stated that cognitive remediation therapy is frequently used for the treatment of psychotic disorders (NAMI, 2017). The literature also showed that cognitive remediation therapy was effective in helping people increase their social functioning (Lindenmayer et al., 2017). This is not consistent with what the sample from the research suggests. A reason for this discrepancy could be that the studies that are being done at the Universities are finding great results, but they are just not incorporated into everyday practice yet. It is possible that they are not incorporated into typical practice because insurance companies are apprehensive to pay for a new treatment model. With these differences, it was not possible to determine if there were any differences in effectiveness of cognitive remediation therapy for those adults with psychotic disorders who experienced childhood trauma versus those who did not.

Strengths and Limitations

One strength of using this qualitative research method is that the information obtained contains quality, concrete examples of what works and does not work when working with adults with psychotic disorders. Another strength is that with an interview like this, there was an opportunity to ask follow-up questions to help understand the data better. Additionally, the

researcher did the interviewing, transcribing and analyzing of the data obtained. This allowed for more consistency throughout the research process. Finally, this method allowed the participants the opportunity to ask clarifying questions that they may not have gotten to ask with other methods.

Though there were strengths to using this method, there were also limitations. The first limitation is that it was hard to find people who knew about psychosis and how to work with clients who were experiencing symptoms. Another limitation is that there was a relatively small sample, so there was no opportunity to generalize information obtained. The researcher originally planned to have at least eight participants, but two of them had to cancel for one reason or another. Additionally, the study lacked male participants and professionals who work in a rural setting. Another limitation is that doing personal interviews took a lot of time and coordination between the different participants and the researcher. Finally, another factor occurring within society, the Florida school shooting, may have influenced the answers that participants gave regarding stigma of mental health.

Implications for Social Work Practice

With the previous literature and the current research study about adults with psychotic disorders, there are many implications for the social work profession. It was difficult for the researcher to find enough people to interview for this study. This was due to the fact that there are not many professionals who work with adults who have psychotic disorders. The researcher found that there is a little niche of professionals in Minnesota who specialize in this that all seem to know each other, but other than that there are not many. This leads to an implication for social work education. Currently, it seems there are not many courses offered that allow incoming professionals to learn about psychosis and how to effectively work with those experiencing it.

From the researcher's experience at St. Catherine University and the University of St. Thomas, there was not even an elective offered about psychosis, which is unfortunate. This may lead to professionals being unprepared when faced with a client displaying psychotic symptoms.

Another implication for social work practice is that psychoeducation may be essential when working with all clients, especially those that have psychotic disorders. This means that professionals need to learn how to properly present psychoeducation that will benefit the clients they are working with. Whether this is taught in the schools of social work or at the agencies themselves, it seems that knowing how to present this information is needed.

Additionally, it was found that there are no differences in the effectiveness of multiple interventions for adults with psychotic disorders who experienced childhood trauma versus those who did not. This implies that social work professionals do not have to focus on the trauma piece of a client's history too much, unless the client asks for it. It seems that interventions that are primarily effective for adults with psychotic disorders who have not experienced childhood trauma, such as antipsychotics, cognitive behavioral therapy and psychoeducation, are just as effective for those who have experienced childhood trauma. Treat all of the clients the same, even if one has experienced trauma because focusing on the trauma too much may make the client shut down and treatment ineffective.

The final implication for social work practice is that cognitive remediation therapy needs to be more available. Professionals need to start advocating for this treatment model to be covered by insurances because it can help with the cognitive functioning of those with psychotic disorders. Whether this means doing more research studies about the effectiveness of cognitive remediation therapy or talking to legislators about the importance, all these actions would be helpful. This would lead to less ethical dilemmas in the field because social workers would not

have to send people to research studies where they do not know if they are actually getting cognitive remediation therapy or not.

References

- Baehler, C., Valiquette, L., Holowka, D., Malla, A., Joobar, R., Ciampi, A., . . . King, S. (2013). Childhood trauma and dissociation in first-episode psychosis, chronic schizophrenia and community controls. *Psychiatry Research, 210*, 36-42.
- Baudin, G., Szoke, A., Richard, J., Pelissolo, A., Leboyer, M., & Schurhoff, F. (2017). Childhood trauma and psychosis: Beyond the association. *Child Abuse & Neglect, 72*, 227-235.
- Bechdolf, A., Knost, B., Nelson, B., Schneider, N., Veith, V., Yung, A., & Pukrop, R. (2010). Randomized comparison of group cognitive behavior therapy and group psychoeducation in acute patients with schizophrenia: Effects on subjective quality of life. *Australian and New Zealand Journal of Psychiatry, 44*(2), 144-150.
- Better Health Channel. (2017). Dissociation and dissociative disorders. Retrieved from <https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/dissociation-and-dissociative-disorders>
- Bosia, M., Buonocore, M., Bechi, M., Spangaro, M., Pigoni, A., Croci, M., . . . Cavallaro, R. (2017). Cognitive remediation and functional improvement in schizophrenia: Is it a matter of size? *European Psychiatry, 40*, 26-32.
- Bremner, J. D. (2006). Traumatic stress: Effects on the brain. *Dialogues in Clinical Neuroscience, 8*(4), 445-461.
- Centers for Disease Control and Prevention. (2016). About the CDC-kaiser ACE study. Retrieved from <https://www.cdc.gov/violenceprevention/acestudy/about.html>
- Chien, W. T., Bressington, D., & Karatzias, T. (2017). An international multi-site, randomized controlled trial of a mindfulness-based psychoeducation group programme for people with schizophrenia. *Psychological Medicine, 47*(12), 2081-2096.
- Chien, W. T., & Lee, I. Y. M. (2013). The mindfulness-based psychoeducation program for chinese patients with schizophrenia. *Psychiatric Services, 64*(4), 376-379.
- Corbera, S., Wexler, B., Poltorak, A., Thime, W., & Kurtz, M. (2017). Cognitive remediation for adults with schizophrenia: Does age matter? *Psychiatry Research, 247*, 21-27.
- Daalman, K., Diederens, K. M. J., Derks, E. M., Van Lutterveld, R., Kahn, R. S., & Sommer, I. E. C. (2012). Childhood trauma and auditory verbal hallucinations. *Psychological Medicine, 42*, 2475-2484.
- Davidson, C., Johannesen, J., & Fiszdon, J. (2016). Role of learning potential in cognitive remediation: Construct and predictive validity. *Schizophrenia Research, 171*, 117-124.

- Evans, G., Reid, G., Preston, P., Palmier-Claus, J., & Sellwood, W. (2015). Trauma and psychosis: The mediating role of self-concept clarity and dissociation. *Psychiatry Research*, *228*, 626-632.
- Finkelhor, D., Turner, H., Shattuck, A., & Hamby, S. (2013). Violence, crime, and abuse exposure in a national sample of children and youth an update. *JAMA Pediatrics*, *167*(7), 614-621.
- Garcia, M., Montalvo, I., Creus, M., Cabezas, A., Sole, M., Algora, M., . . . Labad, J. (2016). Sex differences in the effect of childhood trauma on the clinical expression of early psychosis. *Comprehensive Psychiatry*, *68*, 86-96.
- Hargreaves, A., Dillon, R., Anderson-Schmidt, H., Corvin, A., Fitzmaurice, B., Castorina, M., . . . Donohoe, G. (2015). Computerised working-memory focused cognitive remediation therapy for psychosis - A preliminary study. *Schizophrenia Research*, *169*, 135-140.
- Heins, M., Simons, C., Lataster, T., Pfeifer, S., Versmissen, D., Lardinois, M., . . . Myin-Germeys, I. (2011). Childhood trauma and psychosis: A case-control and case-sibling comparison across different levels of genetic liability, psychopathology, and type of trauma. *American Journal of Psychiatry*, *168*(12), 1286-1294.
- Jahn, T., Pitschel-Walz, G., Gsottschneider, A., Frobose, T., Kraemer, S., & Bauml, J. (2011). Neurocognitive prediction of illness knowledge after psychoeducation in schizophrenia: Results from the munich COGPIP study. *Psychological Medicine*, *41*(3), 533-544.
- Jahn, T., Pitschel-Walz, G., Gsottschneider, A., Frobose, T., Kraemer, S., & Bauml, J. (2011). Neurocognitive prediction of illness knowledge after psychoeducation in schizophrenia: Results from the munich COGPIP study. *Psychological Medicine*, *41*(3), 533-544.
- Jewell, T., Downing, D., & McFarlane, W. (2009). Partnering with families: Multiple family group psychoeducation for schizophrenia. *Journal of Clinical Psychology*, *65*(8), 868-878.
- Kilcommons, A. M., & Morrison, A. P. (2005). Relationships between trauma and psychosis: An exploration of cognitive and dissociative factors. *Acta Psychiatrica Scandinavica*, *112*, 351-359.
- Kingdon, D., & Turkington, D. (2005). Ch. 8: Psychoeducation and normalization. *Cognitive therapy of schizophrenia* (pp. 83-95) Guilford Press.
- Lardinois, M., Lataster, T., Mengelers, R., Van Os, J., & Myin-Germeys, I. (2011). Childhood trauma and increased stress sensitivity in psychosis. *Acta Psychiatrica Scandinavica*, *123*(28), 35.
- Lee, R. S. C., Redoblado-Hodge, M. A., Naismith, S. L., Hermens, D. F., Porter, M. A., & Hickie, I. B. (2013). Cognitive remediation improves memory and psychosocial functioning in first-episode psychiatric out-patients. *Psychological Medicine*, *43*, 1161-1173.

- Lindenmayer, J. P., Fregenti, S., Kang, G., Ozog, V., Ljuri, I., Khan, A., . . . McGurk, S. (2017). The relationship of cognitive improvement after cognitive remediation with social functioning in patients with schizophrenia and severe cognitive deficits. *Schizophrenia Research, 185*, 154-160.
- Mendella, P., Burton, C., Taska, G., Roy, P., St. Louis, L., & Twamley, E. (2015). Compensatory cognitive training for people with first-episode schizophrenia: Results from a pilot randomized controlled trial. *Schizophrenia Research, 162*, 108-111.
- Misiak, B., Moustafa, A., Kiejna, A., & Frydecka, D. (2016). Childhood traumatic events and types of auditory verbal hallucinations in first-episode schizophrenia patients. *Comprehensive Psychiatry, 66*, 17-22.
- National Alliance on Menal Illness (NAMI). (2017). Schizophrenia. Retrieved from <https://www.nami.org/Learn-More/Mental-Health-Conditions/Schizophrenia>
- National Alliance on Menal Illness (NAMI). (2017). *Understanding psychosis: Resources and recovery*. Minnesota: National Alliance on Mental Illness.
- National Children's Alliance. (2015). How the CAC model works. Retrieved from <http://www.nationalchildrensalliance.org/cac-model>
- National Institue of Mental Health. (2017). Schizophrenia. Retrieved from <https://www.nimh.nih.gov/health/statistics/prevalence/schizophrenia.shtml>
- Penades, R., Pujol, N., Catalan, R., Massana, G., Rametti, G., Garcia-Rizo, C., . . . Junque, C. (2013). Brain effects of cognitive remediation therapy in schizophrenia: A structural and functional neuroimagine study. *Biological Psychiatry, 73*, 1015-1023.
- Reeder, F., Husain, N., Rhouma, A., Haddad, P., Munshi, T., Naeem, F., . . . Chaudhry, I. (2017). The relationship between childhood trauma and adult psychosis in a UK early intervention service: Results of a retrospective case note study. *Neuropsychiatric Disease and Treatment, 13*, 269-273.
- Reichart, T., Pitschel-Walz, G., Kissling, W., Bauml, J., Schuster, T., & Rummel-Kluge, C. (2010). Gender differences in patient and caregiver psychoeducation for schizophrenia. *European Psychiatry, 25*(1), 39-46.
- Reininghaus, U., Gayer-Anderson, C., Valmaggia, L., Kempton, M. J., Calem, M., Onyejiaka, A., . . . Morgan, C. (2016). Psychological processes underlying the association between childhood trauma and psychosis in daily life: An experience sampling study. *Psychological Medicine, 46*, 2799-2813.
- Solesvik, M., Joa, I., Ketil Larson, T., Langeveld, J., Olav Johannessen, J., Bjornestad, J., . . . Bronnick, K. (2016). Visual hallucinations in first-episode psychosis: Association with childhood trauma. *Plos One, 11*(5), 1-11.

- Substance Abuse and Mental Health Services Administration (SAMHSA). (2017). Adverse childhood experiences. Retrieved from <https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences>
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2015). Trauma-informed approach and trauma-specific interventions. Retrieved from <https://www.samhsa.gov/nctic/trauma-interventions>
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2016). Types of trauma and violence. Retrieved from <https://www.samhsa.gov/trauma-violence/types>
- Tan, S., Zou, Y., Wykes, T., Reeder, C., Zhu, X., Yang, F., . . . Zhou, D. (2016). Group cognitive remediation therapy for chronic schizophrenia: A randomized controlled trial. *Neuroscience Letters*, 626, 106-111.
- THE BRIDGE. (2017). Illness management and recovery (IMR). Retrieved from https://www.thebridgecm.org/treatment-models/illness_management_recovery.html
- U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families & Children's Bureau. (2015). Child maltreatment 2015. Retrieved from <https://www.acf.hhs.gov/sites/default/files/cb/cm2015.pdf>
- Van Nierop, M., Bak, M., De Graaf, R., Ten Have, M., Van Dorsselaer, S., Genetic Risk and Outcome of Psychosis (Group) Investigators, & Van Winkel, R. (2016). The functional and clinical relevance of childhood trauma-related admixture of affective, anxious and psychosis symptoms. *Acta Psychiatrica Scandinavica*, 133, 91-101.
- Van Nierop, M., Van Os, J., Gunther, N., Van Zelst, C., De Graaf, R., Ten Have, M., . . . Van Winkel, R. (2013). Does social defeat mediate the association between childhood trauma and psychosis? evidence from the NEMESIS-2 study. *Acta Psychiatrica Scandinavica*, 129, 467-476.
- Veling, W., Counotte, J., Pot-Kolder, R., Van Os, J., & Van Der Gaag, M. (2016). Childhood trauma, psychosis liability and social stress reactivity: A virtual reality study. *Psychological Medicine*, 46, 3339-3348.
- Zero to Six Collaborative Group, & National Child Traumatic Stress Network. (2006). Early childhood trauma., 1-17.

Appendix A

Initial Email

Hello _____,

My name is Jennifer Metzger and I am a Master of Social Work candidate at the University of St. Thomas and St. Catherine University. I am currently conducting a research study that is examining professionals' opinions of effective interventions for adults with psychotic disorders who have experienced childhood trauma. I received your contact information from _____, who identified you as a licensed, professional who has experience with adults who have psychotic disorders. I am contacting you to see if you would be interested in participating in my research study. This would require meeting with me in person for a one-hour interview. The interview will take place in a private study room at the main library at the University of St. Thomas. The interview will be recorded on a digital voice recorder that will be kept in my possession throughout the length of the study. All information received from you will be kept totally confidential. Is this something that you would be willing to participate in? If so, I will send you an email with a letter of informed consent and the interview questions, so you can review them before the actual interview. If you have any questions about these documents feel free to call me at: 651-245-9223 or email me at: metz7810@stthomas.edu. Additionally, if you are interested, please send me some dates and times that you are available to meet for an interview.

Thank you for your time,

Jennifer Metzger

Appendix B

Informed Consent

ST CATHERINE UNIVERSITY Informed Consent for a Research Study

Study Title: Professional Opinions of Effective Interventions for Adults with Psychotic Disorders Who Experienced Childhood Trauma

Researcher(s): Jennifer Metzger, B.A., Master's of Social Work Candidate

You are invited to participate in a research study. This study is called Professional Opinions of Effective Interventions for Adults with Psychotic Disorders Who Experienced Childhood Trauma. The study is being done by Jennifer Metzger, a Master's candidate at St. Catherine University in St. Paul, MN. The faculty advisor for this study is Rajean P. Moone, PHD, Graduate School of Social Work at St. Catherine University.

The purpose of this study is to examine professionals' opinions about effective interventions for adults with psychotic disorders who experienced childhood trauma. This study is important because though there is a lot of research on the different interventions, there is a significant lack of literature surrounding professionals' opinions on this issue. Approximately eight to ten people are expected to participate in this research. Below, you will find answers to the most commonly asked questions about participating in a research study. Please read this entire document and ask questions you have before you agree to be in the study.

Why have I been asked to be in this study?

You have been asked to participate in this study because you have been identified by another professional as someone with expertise in this area.

If I decide to participate, what will I be asked to do?

If you meet the criteria and agree to be in this study, you will be asked to do these things:

- Participate in a 60 minute in person interview that will be audio recorded. In total, this study will take approximately 60 minutes over 1 session.

What if I decide I don't want to be in this study?

Participation in this study is completely voluntary. If you decide you do not want to participate in this study, please feel free to say so, and do not sign this form. If you decide to participate in this study, but later change your mind and want to withdraw, simply notify me and you will be removed immediately. You may withdraw up to 30 days after your scheduled interview, after which time withdrawal will no longer be possible. Your decision of whether or not to participate will have no negative or positive impact on your relationship with St. Catherine University, nor with any of the students or faculty involved in the research.

What are the risks (dangers or harms) to me if I am in this study?

There are no foreseen risks to the participants of this study.

What are the benefits (good things) that may happen if I am in this study?

There are no direct benefits to you for participating in this research. However, the data will benefit the mental health field by identifying best practices for those living with a psychotic disorder who have experienced childhood trauma.

Will I receive any compensation for participating in this study?

You will not be compensated for participating in this study.

What will you do with the information you get from me and how will you protect my privacy?

The information that you provide in this study will be recorded via audiotape. The information collected will then be transcribed and printed out by the researcher. Any identifying information about the participant will be removed from the data for confidentiality purposes I will keep the research results in a computer file that is password protected. Any printed material will be kept in a locked drawer of my filing cabinet. Only I and the research advisor will have access to the records while I work on this project. I will finish analyzing the data by June 30, 2018. I will then destroy all original reports and identifying information that can be linked back to you. Only myself and my research committee will have access to the audiotape where you provided research data, they will be destroyed no later than June 30, 2018.

Any information that you provide will be kept confidential, which means that you will not be identified or identifiable in the any written reports or publications. If it becomes useful to disclose any of your information, I will seek your permission and tell you the persons or agencies to whom the information will be furnished, the nature of the information to be furnished, and the purpose of the disclosure; you will have the right to grant or deny permission for this to happen. If you do not grant permission, the information will remain confidential and will not be released.

Are there possible changes to the study once it gets started?

If during the course of this research study I learn about new findings that might influence your willingness to continue participating in the study, I will inform you of these findings

How can I get more information?

If you have any questions, you can ask them before you sign this form. You can also feel free to contact me at 651-245-9223 or metz7810@stthomas.edu. If you have any additional questions later and would like to talk to the faculty advisor, please contact Dr. Rajean P. Moone at rpmoone@stkates.edu. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@stkate.edu.

You may keep a copy of this form for your records.

Statement of Consent:

I consent to participate in the study and agree to be audiotaped.

My signature indicates that I have read this information and my questions have been answered. I also know that even after signing this form, I may withdraw from the study by informing the researcher(s).

Signature of Participant

Date

Signature of Researcher

Date

Appendix C

Interview Questions

1. Can you explain to me what your job title and duties are in your current position?
2. How do you believe validation is relevant to the therapeutic relationship that you have with clients?
3. What do you see as the relationship between childhood trauma and psychotic disorders in adults?
 - a. Is there a specific type of trauma that may be more significant than the other?
4. Can you describe a time that you've had a client living with psychosis who experienced trauma as a child?
 - a. Were there things that differentiated them from other clients? If so, what?
5. What types of interventions do you typically use with clients who have been diagnosed with a psychotic disorder?
 - a. In your opinion, are there certain interventions that work better for or are less effective for those adults with psychotic disorders who have experienced childhood trauma?
 - b. Can you describe a situation in which an intervention worked well / did not work well for a client with psychosis who experienced childhood trauma?
6. What is your opinion of the use of antipsychotics for adults with psychotic disorders who experienced trauma as a child?
 - a. Have you ever had to convince a client to consider using an antipsychotic?
 - i. If so, can you describe this experience?

7. How do you feel about the use of psychoeducation for adults with psychotic disorders who experienced childhood trauma?
 - a. Is there any particular curriculum that you have found to be most effective?
 - b. Have you noticed any differences in the effectiveness of psychoeducation for those that have experienced childhood trauma vs those that have not? How so?
8. Have you ever heard of “normalization” being used as a technique for psychoeducation with this population? (If not, I will explain normalization).
 - a. “A process by which thoughts, behaviors, moods, and experiences are compared and understood in terms of similar thoughts, behaviors, moods and experiences attributed to other individuals who are not diagnosed as ill- especially mentally ill” (Kingdon & Turkington, 2005, p.87).
 - b. How do you address stigma with your clients who have been diagnosed with a psychotic disorder?
 - c. Do you agree or disagree with Kingdon & Turkington’s concept of normalization? Why?
9. How do you feel about the use of Cognitive Remediation Therapy for adults with psychotic disorders who experienced trauma as a child?
 - a. Is this a technique that you have used with your clients in the past?
 - b. Have you noticed any differences in the effectiveness of Cognitive Remediation Therapy for those that have experienced childhood trauma vs those that have not? How so?