



Being in a process of transition to psychosis, as narrated by adults with psychotic illnesses acutely admitted to hospital

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Accessible summary

- Early intervention to prevent and reduce new episodes of psychosis involves patients, relatives and mental health personnel recognizing the early signs of psychosis.
- Twelve participants with psychotic illnesses narrated how they experienced becoming psychotic before they were admitted to acute psychiatric wards.
- The results of this study demonstrate that participants and their close others who sensed, understood and articulated experienced changes as signs of psychosis established a dialogue with mental health personnel and initiated treatment and care. Participants who did not perceive the experienced changes as signs of psychosis articulated the experienced changes as an awareness of a poor health condition and illness. These participants, who had no other people to advocate for them, appeared to experience poor communication and coercion during intervention.

Abstract

To assist in improving early interventions for psychosis, this study explored how adult people narrated their experience of becoming psychotic, and how contact with mental health personnel was established. Narrative interviews were conducted with 12 participants with psychotic illnesses recruited from acute psychiatric wards. The interviews were content analysed. Participants described being in a process of transition to psychosis as follows: experiencing changes as well-known signs of psychosis, experiencing sudden unexpected changes as signs of psychosis and experiencing unidentified changes as signs of illness. Our results show that participants and their close others who knew the signs of psychosis established a dialogue with mental health personnel and were better equipped to prevent and mitigate the psychosis. Our results demonstrate that participants who did not perceive the signs of psychosis and did not have other people to advocate for them were at risk for delayed treatment, poor communication and coercive interventions. Furthermore, participants who did not know the signs of psychosis perceived these changes as deterioration in their health and awareness of illness. We suggest that participants' experiential knowledge of transitioning to psychosis and an awareness of illness can be used to improve the communication during interventions for psychosis.

Introduction

Psychoses are serious and can be lifelong conditions associated with appreciable levels of burden for the affected individuals and their families (Lopez *et al.* 2006). The severity of psychoses has led to the development of early interventions aimed at preventing and reducing new episodes of psychosis. In this paradigm, psychosis is viewed as a fluid syndrome that occurs in episodes, develops in stages that begin with early signs of psychosis and are defined by symptoms, including hallucinations, delusions and formal thought disturbances (McGorry *et al.* 2008). Preventing efforts are described in clinical guidelines for treatment and follow-up for people with psychotic illnesses in the following steps: (1) to reach people with psychosis by the detection and recognition of early signs of psychosis by patients and/or relatives and local mental health personnel; (2) to establish contact between patients and mental health service; and (3) to offer individual and stage-specific interventions. Interventions for people with psychosis are primarily offered in local mental health services and secondarily in acute psychiatric wards to people with acute psychosis (Norwegian Directorate of Health 2013). Early interventions include a variety of approaches as antipsychotic medication, cognitive therapy, family therapy, care, employment and social support to people in risk of new episodes of psychosis and their families (van Meijel *et al.* 2002, McGorry *et al.* 2008). The growing evidence from national studies for the effectiveness of early intervention approaches in preventing new episodes of psychosis (McGorry *et al.* 2008) supports that it is important to reach and access people with psychosis, not asking for or not wanting treatment (McGorry *et al.* 2010, Birchwood *et al.* 2013).

We reviewed previous literature with different qualities and approaches to broaden our insight about early interventions for people with psychosis. Studies investigating the effectiveness of early interventions confirmed that the early signs of psychosis are reliable markers that aid in the early identification of psychosis (Yung & McGorry 2007, Iyer *et al.* 2008). Other studies showed it is possible to treat young people with psychosis with fewer inpatient days and less use of medication with early approach combined with intense psychosocial treatment and support (Cullberg *et al.* 2002, 2006). Review studies reported that early interventions were effective for early psychosis and could reduce durations of untreated psychosis (Killackey & Yung 2007), furthermore, there was emerging but inconclusive evidence that people with prodrome could be helped with interventions, and support for the effectiveness of phase-specific treatments focused on employment and cognitive therapy for people with psychotic illnesses (Marshall & Rathbone

2011). Stafford *et al.* (2013) found no evidence for specific interventions to prevent psychosis, although findings supported the possibility to prevent transition to psychosis. Bosanac *et al.* (2010) showed that there was a lack of evidence that early interventions did much for people with illnesses associated with poor prognosis. A recent review study suggested community education and awareness campaigns related to the signs of psychosis to shorten delays in mental health services to reduce durations of untreated psychosis (Birchwood *et al.* 2013). Other researchers suggested improvements in outreach services to reach people with psychosis (Cotton *et al.* 2007, Hasselberg *et al.* 2011).

Researchers exploring people's subjective experiences of becoming psychotic described fundamentally changed perceptions of the world (Sass 1988), difficulties with articulating experienced changes and disturbances in the sense of self (Møller & Husby 2000, Parnas & Handest 2003), feeling lonely and hopeless (Barker *et al.* 2001) and becoming psychotic as a journey towards an uncertain future (Hardy *et al.* 2009). Psychosis changed people's perceptions, social behaviours and communication (MacDonald *et al.* 2005), their ability to advocate for themselves and prompted them to become suspicious (Leiviska Deland *et al.* 2011). Studies exploring people's help-seeking experiences reported their need for knowledge about psychosis and interventions by health professionals (Tanskanen *et al.* 2011) and their need for significant others as crucial in seeking help (Anderson *et al.* 2012). Published personal narratives, authored by patients themselves, gave detailed insight in what each of the narrators had to overcome in their 'journeys' in and out of psychosis and how psychosis changed their daily living (Grant *et al.* 2011, Lauveng 2013).

Our review showed support for the effectiveness of early interventions to prevent and reduce psychosis for some people with psychosis; however, with limited effects for people with psychotic illnesses associated with poor prognosis and people with psychosis not asking for treatment and care. The studies exploring people's experiences gave insight in how psychosis affected their social skills and their help seeking and the personal narratives deepened this understanding. These findings made us aware of the outlined steps of early intervention for psychosis: (1) to reach people becoming psychotic; (2) to establish contact between people becoming psychotic and mental health personnel; and (3) to offer and initiate treatment and care. We questioned how people experienced becoming psychotic and experienced their need for treatment and care prior to the steps of early interventions of psychosis; to address this question, we searched for research studies. The results were limited, but a study reviewing patients' and clinicians' different explanatory models about psychotic sickness and

treatment suggested that the difference in the models may impact durations of untreated psychosis and therefore should be further examined (Bhikha *et al.* 2012). We designed a study aimed at increasing the understanding of people’s experience of becoming psychotic to improve early interventions for psychosis. The theoretical framework of this study is based on the perspective of human experience in illness narratives to access people’s described processes of psychosis as well as their need for treatment and care (Kleinman 1988). Furthermore, narratives provided an understanding of the interplay between cognition, emotion, volition and action in the experience of becoming psychotic (cf. Tappan & Brown 1989).

People with psychosis who have been acutely voluntarily or involuntarily admitted to psychiatric wards, possess important knowledge regarding their experiences of becoming psychotic and their needs for treatment and care. Their experiences may increase the understanding about becoming psychotic and contribute to improve interventions for psychosis. The aim of our study was to explore the experiences of becoming psychotic among people with psychotic illnesses prior to interventions and admittance to acute psychiatric wards.

Methods

A qualitative exploratory design was chosen and narrative interviews (Mishler 1991) were used to assess participants’ illness experiences.

The setting for our study included four psychiatric wards in departments of general psychiatry in two hospitals in Norway providing treatment and care to people in the acute phases of psychosis. Participants were recruited among inpatients, and selection criteria for participants were as follows: acutely admitted to the hospital; involuntarily and voluntarily admitted; different psychotic disorders; and able to narrate their experiences regarding

psychotic illness and admittance to the hospital. The chief physician confirmed the patients’ participation in the study. Patients were informed about the study and were asked to participate and to sign an informed consent. The participants were eight women and four men, varying in age, from 18 to 64 years, who were being diagnosed with psychotic illnesses. Eight of the participants were involuntarily admitted for treatment and care. Participants were purposively recruited, and no further recruitment was conducted when the interviews no longer revealed any new information about the research topic.

The first author (KS) conducted interviews between December 2008 and May 2009 during the participants’ hospital stay. The opening statement was ‘Please tell me what brought you to the hospital’. An invitation to narrate about the experience of becoming psychotic ill followed, and K.S. encouraged the participants gently to narrate what seemed important to them of what happened. Participants described their experienced changes related to their psychotic illness and how the changes affected their daily lives. K.S. was attentive to participants’ use of terms about their illness experiences and was sensitive when asking clarifying questions and used their chosen words, such as, ‘How did you sense the strange impressions that intruded you? How did you interpret, understand, feel and act?’ The tape-recorded interviews lasted 50–90 min and were transcribed verbatim by K.S.

A qualitative content analysis (Graneheim & Lundman 2004) was applied. The total interview–text was read several times to understand the content as a whole. Sections of the text related to the participants’ narrated experiences of becoming psychotic were brought together into one text, a content area. This text was then divided into meaning units that were condensed and labelled with codes. These coded meaning units were compared and sorted into subcategories. Further comparison led to the construction of categories (Table 1). The underlying meaning of the

Table 1

Example of analysis

Meaning unit	Condensed meaning unit	Code	Sub-category	Category
It went slowly downhill. I noticed ‘mood’. A new day’s mood is not as yesterday’s mood (10)	Sensing known changes slowly growing in volume	Noticing changes Slowly changes	Noticing well-known changes directly related to time	Experiencing changes as well-known signs of psychosis
I sense when I am close to psychosis. I know the signs. First, I get worried, and then the voices become more aggressive. It is like the voices grow in volume inside me (12)	Sensing well-known changes which grow inside the body	Knowing changes Increasing intensity of changes	Sensing well-known changes	

Table 2
Categories and subcategories

Categories	Subcategories
A. Experiencing changes as well-known signs of psychosis	Noticing well-known changes directly related to time Sensing well-known changes Understanding well-known changes as signs of psychosis Dealing with well-known signs Articulating well-known signs
B. Experiencing sudden unexpected changes as signs of psychosis	Noticing sudden unexpected changes directly related to time Sensing sudden unexpected changes Understanding sudden unexpected changes as signs of psychosis supported by close others Dealing with signs of psychosis supported by close others Articulating signs of psychosis supported by close others
C. Experiencing unidentified changes as signs of illness	Noticing unidentified changes implicitly related to time Sensing unidentified changes Being aware of unidentified changes Dealing with unidentified changes without support Articulating unidentified changes without support

categories and subcategories was interpreted and formulated as the theme of 'being in a process of transition to psychosis' (Table 2).

Methodological considerations

To ensure the reliability, validity and thus trustworthiness of our approach, we considered methodological issues throughout the research process (Morse *et al.* 2002). We verified and confirmed the data during data collection by discussing the breadth, depth and nuances of the interviews within the research team; this gave K.S. the opportunity to modify subsequent interviews to ensure the sufficiency of the data. During the analysis, the second and third authors brought different perspectives from K.S. as well as additional questions. As a team, we discussed the chosen focus, coding strategy, creation of subcategories, categories and theme. This process provided the opportunity to explore and reflect upon the results and ensure that participants' voices were heard throughout the research.

Ethics

The study was approved by the Norwegian Social Science Data Service (15721/2006) and the Regional Committee for Medical and Health Research Ethics (110/2006). Participants were guaranteed confidentiality and anonymous presentation of the results. Participants' names and personal information were saved in secure computer files and were not used in the interview text. Participants were assured of their right to withdraw from the study before data were included in the analysis without stating a reason and with no consequences for their treatment and care.

Results

The theme 'Being in a process of transition to psychosis' linked the underlying meaning of three categories, each of which contained five subcategories (Table 2).

These categories of transitions to psychosis were as follows: experiencing changes as well-known signs of psychosis (A), experiencing sudden unexpected changes as signs of psychosis (B) and experiencing unidentified changes as signs of illness (C). The term 'sign' relates to the experienced changes noticed by participants, relatives and health personnel that may signal new episodes of psychosis (cf. Birchwood *et al.* 2000). All participants are quoted and labelled as 1–12. We use the term 'close others' to refer to participants' relatives, friends and mental health personnel who the participants reported having continuous contact with.

A. Experiencing changes as well-known signs of psychosis

The first category described participants' transitioning process as being familiar with their psychotic illness, and well-known signs of psychosis are expressed as important signals to seek treatment and care to prevent becoming psychotically ill.

Noticing well-known changes directly related to time

Participants noticed non-specific changes occurring slowly. They described the beginning and the length of time the changes lasted in terms of days, weeks and even months. One participant recounted:

It went slowly downhill. I noticed 'mood'. A new day's mood is not the same as yesterday's mood when you start getting ill. The changes lasted 2 or 3 months before I went to the hospital (10).

Sensing well-known changes

Participants described sensing different changes that increased in intensity. They recognized these changes as signs of psychosis based on earlier experiences. One participant described a restless body and an inability to concentrate on daily activities. Another participant described mood changes, nightmares and the feeling of being burned and falling down in the darkness. Participants expressed the experience of hearing voices that harassed them and/or tried to persuade them to do bad things; they also described increased anxiety. They adapted to the progression of signs by closely noticing them. One man described:

I sense when I am close to psychosis. I know the signs. First, I get worried, and then the voices become more aggressive. It is like the voices grow in volume inside me (12).

Understanding well-known changes as signs of psychosis

Participants understood the experienced changes as early signs of psychosis. They knew psychosis to be painful and wanted to prevent it. One participant recounted:

I know what becoming ill involves. This time it was easier for me to be in charge of my illness. I have more knowledge now (10).

Dealing with well-known signs

Participants used coping strategies to maintain control over the increasing changes. They described focusing on daily routines and paying attention to or ignoring the increasing voices they heard. Participants described taking antipsychotic drugs and other medications or alcohol to reduce disability; they reported contacting mental health services for support. Based on previous experiences, they knew they could reduce and/or stop psychosis with adequate efforts. This time, the signs evolved and made them aware of their need for help. One participant explained:

I had symptoms of mania. I started to spend money. I got problematic to read and do daily activities. I could not find peace in my apartment any longer. I walked down to the emergency clinic and talked with the nurse (5).

Articulating well-known signs

Participants contacted mental health personnel and described their experienced changes as signs of psychosis that indicated their need for treatment and care. One woman said:

I called the emergency clinic and got a nurse on the phone. I just said how it was. The voices I heard told me to harm my father. She understood it was serious and contacted the hospital (9).

B. Experiencing sudden unexpected changes as signs of psychosis

The second category described participants' transitioning process as the onset of sudden and unexpected changes that overwhelmed them and reduced their ability to deal with the changes on their own. Close others observed signs of psychosis and contacted mental health personnel, and the participants accepted treatment and care.

Noticing sudden unexpected changes directly related to time

Participants described sudden changes in their health condition and reported knowing the exact day this change occurred. One woman said:

I was home in my apartment and about to clean the bathroom. It was acute, like snapping my fingers. It happened from Thursday to Friday (1).

Sensing sudden unexpected changes

Participants reported overwhelming changes and described them as unexpected, intense sensations different from symptoms present in their daily lives. They described increasing energy, voices that suddenly became scary and demanding, situations where things in the environment took on special meanings and thoughts became twisted. Participants described intruding impressions and recalled hearing that relatives spoke with 'double voices'; they described being obsessed during activities and that impressions overwhelmed them and displaced their emotions. One woman explained:

It feels like I am closed or turned off. I do not think I love my children anymore (7).

Understanding sudden unexpected changes as signs of psychosis supported by close others

Participants described that changes occurred suddenly and unexpectedly. They reported not having the ability to think clearly and described an intense fear of losing control and/or of harming someone or themselves. They described having a vague understanding of being psychotic that became clearer when close others articulated their observations of psychosis; however, the intense changes took all of their attention, created fear and reduced their capacity to relate to people. One man recounted:

When you are in this situation, a paranoid psychosis, you only think that the worst will follow. You think someone will shoot you, strange things, and you draw the wrong conclusions, even if you know deep down in yourself everything will be as before (11).

Dealing with signs of psychosis supported by close others

Participants described their fight to maintain control over the changes. One man described himself as frozen when

trying to maintain control. Participants claimed to be unable to seek help. However, participants acknowledged they were lucky to have their close others who understood the signs of psychosis and contacted mental health personnel. One woman recalled:

Suddenly I thought, 'I am going to die anyway'. One nurse understood something was wrong with me; he came and found me in the garage. I was about to commit suicide. He saved me and got me to the hospital (4).

Articulating signs of psychosis supported by close others

Participants described being unable to articulate their condition and explained the feeling of being locked inside their body or that their speech was changed or blocked. Thus, it was necessary for their close others to speak on their behalf and to contact mental health personnel. They reported that close others described signs of psychosis to the mental health personnel and treatment and care were immediately offered. One participant said:

I was in a psychotic state, and it was difficult to distinguish between what was real and what was not. In that situation, I was not in a condition to do anything. Thanks to my parents, I got help. They decided to call for help (11).

C. Experiencing unidentified changes as signs of illness

The third category described the transitioning process to psychosis as unidentified changes participants sensed but struggled to understand, address and articulate. They described the absence of close others they related to that were concerned with their unidentified changes. They described the interventions from authorities (e.g. police, physicians and mental health personnel) as coercive.

Noticing unidentified changes implicitly related to time

Information about time was lacking in participants' narratives. Participants described unidentified changes experienced prior to hospital admittance and connected to events, places and people. When they were asked when the changes started, participants answered metaphorically. One participant related the changes to Good Friday. He expressed it like this:

I think about it as I restarted. It was on Good Friday. It was then that I started again on the school of life (6).

Sensing unidentified changes

Participants described sensing unidentified changes. One participant explained her face and body changed. Participants described the feeling of being weightless and that food began to taste bad; they expressed clearly seeing how

different events were chained together and having visions about the reality of situations. They described strange thoughts they could not control, intense anxiety, unpleasant sensations, feelings of illness, abundant energy or becoming fatigued. Participants recalled feeling insecure, of not belonging anywhere and having thoughts about changing their name and nationality. Some participants described positive changes. For example, one woman stated:

I heard my mother and father. I could hear them when it was quiet. They sat drinking their coffee, just as it was back then. It was good and cosy (3).

Being aware of unidentified changes

When participants recalled their experiences, they described neither knowing nor understanding what the changes meant. They described being in poor health and the awareness that something was wrong. Participants described searching for meanings and explanations for their experiences and contacted mental health personnel for treatment. One participant said:

I had intense pain in my arms and it was like a 'bird-nest'. I could not sleep, had a lot of energy and had problems at work. I told my general physician and got physiotherapy (2).

Dealing with unidentified changes without support

Participants described their fight to cope with the unidentified changes. They worked harder, travelled, stayed in bed, isolated themselves and/or stopped taking medication to reduce the discomfort. Some described their changes as being physically unwell. They contacted health personnel, but did not succeed in explaining their complaints and getting appropriate help. They did not talk with close others about the changes because they felt they would not understand them. At some point in time, they described that authorities (e.g. police, physicians and mental health personnel) intervened. In some cases, the interventions were made through physical coercion, which participants experienced as painful and shameful; the participants claimed they were treated with a lack of respect. One participant recounted:

I was squeezed against the wall, and the police held my arms very hard. I turned toward him and spat at him. I did not have anything else to do. They laid me down, and I got an injection. I felt I could not breathe (8).

Articulating unidentified changes without support

Participants explained they were afraid and confused about the changes and had problems articulating their condition to mental health personnel when the authorities intervened. They claimed the authorities ordered them to go to the hospital. When that situation occurred, participants

expressed a need to be connected with their close others. In some cases, they described acting out their frustrations and having the feeling of being isolated. When recalling the event, participants searched for words and used metaphors to express their experiences. They reported getting sad or angry and questioning the authorities' communication skills. One participant said:

They said I was to go to the hospital. I felt desperate and said, 'This cannot be true. You have to call my sister.' No! They took me out, and I got power and ran off to a store. I wanted someone to witness what was happening to me (2).

Discussion

The analysis and interpretation of participants' narratives about becoming psychotic revealed the following theme: being in a process of transition to psychosis. Transition means 'to go across', i.e. to pass or move from one state, condition or place to another (Reber *et al.* 2009). Transitions to psychosis are individual (Birchwood *et al.* 2000) and differ according to the specific psychotic disorder (Yung & McGorry 1996). Illness narratives differ according to the individual's illness, earlier experiences and ability to articulate his or her experiences. Moreover, the narratives differ according to whom the individual narrates and in what context (Frank 1995). This study is limited by the participants' abilities to recall their experiences of becoming psychotic and their willingness and ability to narrate. We do not know whether participants described exactly what happened; we know what the participants described. Participants' narratives about becoming psychotic are their unique way of expressing their illness experiences, their perceived symptoms and needs and their experiential accounts contribute to uncover differences in becoming psychotic, which are important for conducted interventions for psychosis.

Participants described different transitions through their experienced changes expressed as well-known signs of psychosis (A), sudden unexpected changes as signs of psychosis (B) and unidentified changes as signs of illness (C). These experiences reminded us of Toombs's (1988, p. 214) discussion that the illness precipitates changes in people's sense of self and body, both as the experiencing subject and the experienced object. In this perspective, the participants' awareness of changes can be predictable signs of psychosis (cf. Birchwood *et al.* 2000). Our results indicate the transitions were different based on how participants noticed changes related to time and how they sensed, understood, dealt with and articulated these changes. We also reported on the differences related to the participants contacting mental health personnel. Participants reported that they

themselves (A) or their close others articulated the experienced changes as signs of psychosis when contacting mental health personnel (B). Other participants articulated unidentified changes as a poor health condition that they described in metaphors when authorities intervened with coercion (C). These participants described the absence of close others to advocate for them. We discuss our results by highlighting these differences in the transitioning process.

Some participants expressed noticing changes over a period or at a specific moment in time (A, B). By stating when the changes began, participants distinguished these changes from ordinary health conditions and expressed some control over their illness. These results are consistent with studies reporting that some patients describe knowledge about the time related to the development of psychosis (Birchwood *et al.* 2000, Ruhrmann *et al.* 2009). Other participants associated the changes with events, places and people in their narratives (C). These results correspond with a report by Holma & Aaltonen (1998) that acute psychotic patients express an awareness of time through their narratives. Our study showed that all participants expressed an awareness of time when recalling their experiences about becoming psychotic but in different ways. Some participants (A, B) expressed time precisely related to when changes started and other participants (C) described time imbedded in their narratives expressed vaguely or in metaphors.

Participants described sensing changes as well-known signs of psychosis (A), as sudden unexpected changes (B) or as unidentified changes (C). They described changes that evolved in intensity and the fear of losing self-control due to the increased intensity of changes (A–C). Our results correspond with studies describing transitions to psychosis that begin with early non-specific signs of psychosis and progress to a psychotic state (Yung & McGorry 2007, Iyer *et al.* 2008) and disturb the patient's sense of self (Lysaker & Lysaker 2005, Roe & Davidson 2005). Our study provides insights into how participants describe psychotic signs physically and concretely. Moreover, we report on how these signs demand the participants' attention, threaten their sense of self, make it difficult for them to relate to other people and affect their perception of the world.

Participants demonstrated understanding changes in relation to their own and their close others' previous experienced psychosis as knowledge about the signs of psychosis (A, B). Participants who expressed unidentified changes described poor health and their search for an explanation for their condition (C). These results correspond with studies arguing that patients' insights into their psychoses encompass more than insights into the disorder and treatment; it also involves experienced changes and limitations in daily lives as an awareness of illness (David 1990, Roe *et al.* 2008). Researchers also argue that

patients' private perspectives on their situations can express their search for the meaning of their experience, not necessarily a lack of insight (Werbart & Levander 2005, Tranulis *et al.* 2008). Our study showed that participants describing unidentified changes as poor health conditions had difficulty articulating this understanding to mental health personnel.

Participants described dealing with changes as interventions initiated by them (A) or close others (B). These results are consistent with studies describing patients', relatives' and nurses' knowledge about psychosis and coping skills as significant factors related to the management of patients' psychoses (Mueser *et al.* 2006, Lincoln *et al.* 2007) and the role of significant others in reducing misunderstandings with mental health service (Anderson *et al.* 2012). Participants described interventions conducted by authorities (C) as being executed without consideration for the participants' awareness of their illness. They described these interventions as physical and traumatic. These results correspond with studies seeking to develop approaches to reduce coercion and to make treatment and care more secure for patients (Andreasson & Skärsäter 2012, Soininen *et al.* 2013). Our study shows that the physical aspect of the crisis interventions was an extra burden for people transitioning to psychosis.

Participants reported the process of articulating changes during transitioning as experiencing no changes in their language and speech (A), as blocked speech (B) and as having problems articulating unidentified changes which participants related to as feeling isolated (C). These results correspond with reported changes in language and speech as psychotic symptoms (Mould *et al.* 2010). Furthermore, our study shows how participants expressed the need for others to advocate for them and to communicate with them when changes in their language occurred. These results strengthen the arguments for a dialogical approach for patients with psychosis and their families during this phase of interventions for psychosis (cf. Seikkula *et al.* 2003).

To the best of our knowledge, we are the first to explore people's experience related to the phase of time prior to early interventions for psychosis, when people transition to psychosis. The new knowledge from our study can be highlighted as follows: Participants and their close others who understood and articulated experienced changes as signs of psychosis established a dialogue with mental health personnel about treatment and care. Participants who did not understand the experienced changes as signs of psychosis, but as poor health using metaphors in their explanations about their health, and had no one to advocate for them experienced poor communication during interventions. This new insight is revealed from the participants' narratives from the pre-interventional phase to enable

improvements in the interventions for psychosis. This insight can reasonably be transferred to other contexts where health personnel establish contact with people transitioning to psychosis.

Conclusions

Participants who knew and articulated the signs of psychosis on their own or who were supported by close others had an increased chance of getting treatment and care and preventing or reducing the critical phase of psychosis. Participants who expressed an awareness of unidentified changes as signs of illness, such as a poor health condition and not as signs of psychosis, used metaphors to articulate their health condition and had no support from close others were at risk for delayed treatment and/or coercive interventions. These results provide important information for improving communication during the three first steps of intervention for people transitioning to psychosis. Further research and clinical improvements are needed to develop approaches for interventions that take this experiential knowledge into serious consideration.

Implications for practice

The results in our study suggest there is a need for improvements to the communication during interventions for psychosis and that this communication should include participants' experiential knowledge of transitioning to psychosis. Mental health personnel, such as general physicians and mental health nurses/workers in the local mental health services, are often involved in interventions for people becoming psychotic. We suggest the development of guidelines for mental health personnel related to the three steps of early intervention for psychosis: to reach, to establish contact with, and to offer and start treatment and care for people transitioning to psychosis. Such guidelines can be supplemented with existing guidelines for the treatment and follow-up for people with psychotic illnesses.

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