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Title: A longitudinal qualitative follow-up study of posttraumatic growth among service users who experienced positive change following a first episode of psychosis

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Abstract

Objectives: Posttraumatic growth refers to the positive psychological changes that people experience following an adverse event; and has been reported among people who have experienced a first episode of psychosis. This body of research has an important limitation of not having examined how experiences of posttraumatic growth following a first episode of psychosis change over time. In this study, we examined different aspects and facilitators of posttraumatic growth approximately one year following participants' initial interview. **Methods**: Data were collected via semi-structured individual interviews with seven participants and analyzed using thematic analysis. Themes generated from the follow-up interviews were compared with those developed from the initial interviews. **Results**: Participants experienced challenges at the intersection of trauma, social adversity, and oppression; yet they also reported an improved sense of self; improved relationships with others; embracing existing or new activities; and engaging with and giving back to others. These changes were facilitated by personal resources; social and community-based support; and traditional mental health services and interventions. Conclusions: Posttraumatic growth may continue over time. The broader social determinants of health that may lead to a resurgence of psychosis and potential challenges to posttraumatic growth, such as inequality, poverty, and discrimination, should be addressed.

Keywords: Posttraumatic growth; first episode psychosis; qualitative; longitudinal; subjective experience; interview

Background

Posttraumatic growth (PTG) refers to the positive psychological changes experienced following adversity or trauma. PTG is often experienced alongside significant levels of posttraumatic stress and occurs in at least five domains: developing improved relationships with others, new appreciation for life, new possibilities, increased personal strength, and spiritual or existential growth (Tedeschi et al., 2018). In contrast, clinical recovery reflects a return to baseline or normality, and is defined as the resolution of symptoms and the restoration of functioning. Personal recovery reflects broader areas of improvement following a mental health crisis, such as restoring a sense of hope and developing goals for the future and is thus a broader process than PTG (Jordan et al., 2020b). Finally, PTG differs from resilience, which has been described as stable or healthy psychological functioning both prior to, and following an adversity (Infurna & Jayawickreme, 2019).

PTG has been reported following cancer, natural disasters and war (Hefferon et al., 2009; Shakespeare-Finch & Lurie-Beck, 2014). The last decade has witnessed burgeoning research on PTG following psychosis. Studies have shown that such growth may be facilitated by factors inherent in people themselves, their relationships, the broader contexts in which they live, and the quality of mental healthcare they receive (Ng et al., 2021; Mapplebeck et al., 2015; Mazor et al., 2018, 2019; Slade et al., 2019). These studies can provide people who have experienced psychosis with hope for the future, a foundational element of recovery.

Initial interviews that we conducted on this topic revealed that following a first episode of psychosis, participants experienced PTG at the level of the self, relationships with others, and

spiritually (Jordan et al., 2019); and that such growth was influenced by personal, social and spiritual factors, as well as mental health services (Jordan et al., 2020a)

Studies thus far have revealed important insights into PTG following psychosis measured at one timepoint (Dunkley & Bates, 2007; Dunkley & Bates, 2015; Mapplebeck et al., 2015; Mazor et al., 2018, 2019; Pietruch & Jobson, 2012; Slade et al., 2019; Wang et al., 2019). Findings from two systematic reviews revealed that no study has examined aspects and facilitators of PTG following a first episode of psychosis over time (Jordan et al., 2018; Ng et al., 2021). Addressing this knowledge gap can reveal if PTG fosters a greater capacity to cope with subsequent challenges; how PTG influences, or is influenced by, recovery; and insights into how facilitators of growth change over time.

We sought to address this knowledge gap by conducting a longitudinal follow-up study to examine aspects and facilitators of PTG following a first episode of psychosis one year following people's *initial* accounts of PTG.

Our research objectives were to examine: 1) events and challenges participants experienced since their *initial* interview 2) if and how participants changed since the *initial* interview, and 3) what participants felt contributed to those changes.

Methods

Overall Approach

This study was part of a larger mixed methods study examining PTG following a first episode of psychosis (Jordan et al., 2016). A constructivist paradigm guided this study (Guba & Lincoln, 2005), which acknowledges the possibility of multiple realities based in social interactions. Epistemologically, the researcher and subject matter are related, and data arise from co-created meanings.

A qualitative descriptive approach guided the study, whereby data collection and analysis are encouraged to remain close to the experiences of participants themselves while also allowing for a rich interpretation of the findings (Sandelowski, 2010).

Setting and Participants

Participants were recruited from a specialized early intervention service for first episode psychosis that provides care for up to two years. Care includes intensive case management; psychoeducation; supported employment and housing; medication; family peer support and individual family intervention; and psychotherapy. The service is based in an urban catchment area of approximately 400,000 people. Eligibility criteria of the service include being between the ages of 14 and 35; having an IQ of at least 70; experiencing a first episode of psychosis unrelated to an organic brain condition; and having previously taken antipsychotic medication for no more than 30 days (Iyer et al., 2016).

To be eligible for participation in the *initial interview*, participants (n = 12) had to be at least 18 years of age; enrolled at the service for at least six months; fluent in English or French; and not actively experiencing a relapse as defined in clinician reports. The six-month time criterion was chosen because we felt it would not be ethical to ask people to engage in research early on when they may be struggling with immediate aftermath of psychosis. To capture rich experiences of PTG, we purposefully sampled people who reported experiencing PTG during a clinical encounter. We relied on this recruitment strategy to gain approval to conduct the study from the study site.

All participants who took part in the *initial interview* were eligible for participation for a *follow up interview* after a minimum of one year. This time period was chosen to help ensure that enough time had passed for new life experiences to occur. Although participants were not

actively experiencing a relapse during the time of the *follow-up* interviews, many experienced a relapse followed by long, sometimes recurring hospitalizations as well as ongoing symptoms of psychosis and other challenges between the *initial* and *follow-up* interviews. Seven out of the twelve participants who completed the *initial* interview participated in the *follow-up* interview (Table 1). Reasons why participants disengaged were not collected.

Data collection

Data were collected through semi-structured, individual interviews using a guide that assessed the events and challenges that occurred since the *initial interview*, how participants felt they changed, and what participants felt facilitated those changes. Notes chronicling thoughts and reflections about each interview were taken. Interviews were audiotaped, transcribed verbatim, and checked for accuracy by two researchers.

Data Analysis

A recurrent cross-sectional approach was used, which is the most common approach to analyzing longitudinal data in healthcare. Data collected at each timepoint were analyzed independently and compared. This method is appropriate to use when examining themes and sample-level changes over time and when comparing data collected at two timepoints, particularly if follow-up data cannot be collected (Grossoehme & Lipstein, 2016). This method was advantageous because it allowed us to compare qualitative findings from *initial* interviews to quantitative data collected at the same time (Jordan et al., 2016)

Data were analysed using reflexive thematic analysis (Braun & Clarke, 2006, 2020), which is is best suited for understanding experience and "critical framings of meaning" [p4, (Braun & Clarke, 2020)]. Initially, the first author read entire transcripts to develop a deep understanding of participants' experiences. Notes and analytic memos were made during this

process to organize and interpret the findings. Then, he applied inductive and deductive codes to the transcripts. Codes reflected participants' experiences and the team's theoretical and clinical knowledge of PTG. Illustratively, most codes were developed to capture participants' own experiences (e.g., the code "play with my daughter"); however, some segments of text matched theoretical constructs of PTG, and were labelled as such (e.g., the code "spiritual growth"). Sentences often contained multiple, overlapping codes and both inductive and deductive codes were applied to most sentences. Codes were organized into focused codes, subthemes and themes. Then, themes were organized according to an overarching story. All codes were checked against quotes, themes and the overall thematic story. The congruence between themes and quotations were examined by the study team.

The first author engaged in reflexive practice to examine how his multiple brought selves shaped the methods and findings (Reinharz, 1997).

Ethics

Participants provided written consent to include material pertaining to themselves, and they were informed that they cannot be identified via the paper. Participants were told that they did not have to answer questions that could make them feel uncomfortable; could stop the interview at any time if they were experiencing discomfort or distress; and were able to discuss distress arising from the interviews with the clinic's treatment team. Participant identities are fully anonymized. The project was approved by the McGill University Institutional Review Board.

Results

Objective one: to explore events and challenges participants experienced since their *initial* interview

Our analysis produced one theme which described what had transpired since the *initial* interview: *challenges at the intersection of trauma, social adversity and oppression*. Several participants described experiencing ongoing struggles within their families, while others experienced new mental health challenges, which they described using different terms (e.g., depression, psychosis, trauma, extreme states). Many contextualized these challenges within the social, economic, and political adversities they were facing and that are consistent with struggles of people who have been marginalized because of their race, ethnicity, mental health and gender. Such experiences included being mistreated, disrespected, and dehumanized at work; being subject to police intervention prior to hospitalization; losing supports that participants drew on to succeed or remain in school; experiencing sexism, ableism, gender-based discrimination and transphobia; as well as feeling pressured to be productive at work:

"I loved my job, absolutely loved it, but I felt that I wasn't being respected by the owners who were there all the time, except when they were on vacation…Sometimes the chef…would yell at me sometimes and so they were a bit rough with me (P2)"

"My personal wellbeing and mental health is ridiculously correlated to my struggles as a person of, like lesser economic opportunity and my gender, and my sex at birth and, all these things are playing into it, right? (P7)*"*

Furthermore, some who experienced new mental health challenges described how they had not heeded the wisdom gained following their original mental health challenge one year ago, and instead fell back upon old habits (e.g., continuing to be dishonest with oneself, communicating thoughts and feelings):

"I learned this with my ex the first time [to be honest with oneself and more communicative with others], and then it happens again the second time- how many more times is it going to take for me to just be honest? (P2)"

Objective two: To explore if and how participants continued to change since the *initial* interview

Our analysis revealed areas of growth that had been maintained since the *initial* interview as well as new areas of growth. *Initial* interview themes between participants who disengaged and remained engaged in the study were similar. Since five participants disengaged from the study, it may be false to assume that these findings pertain to the original participants.

Five themes describing participants' PTG experienced since their *initial* interview were developed: *improved sense of self; improved relationships with others; embracing existing or new activities*; *spiritual/religious growth*; *and a greater willingness to engage with and give back to other people and communities.*

Improved sense of self. Participants described continuing to mature, grow, and transform following the first episode of psychosis as well as following the new challenges that emerged since their *initial* interview. Participants also described becoming more open, authentic and in sync with their values since the *initial* interview; as well as feeling stronger and tougher than before. For some, such growth involved finding ways to merge new and pre-psychosis aspects of the self:

"*Some of the things that I thought I had before, they're coming out now again and they're re-emerging. And I thought I was a completely different person the last time we spoke. I was like "I'm a completely different person now", and I am in a lot of ways. But some of the characteristics that I had before are still present and now they're starting to emerge again and now there's space for that. (P6)"*

This continued movement towards authenticity was built upon new skills that participants developed, such as becoming more mindful, grounded, and finding new ways to listen to what their bodies, minds and emotions were telling them with greater humility than before the first psychosis; and having greater strength and confidence to delineate what they deserved from other people:

"Yeah so since last May, I am more confident. My confidence is back 100% and it's not going to break. (P4)"

Consistent with the changes described during their *initial* interview, participants continued to develop important realizations about themselves, others, and the world, such as developing a deeper understanding of time and one's capacity to heal. They also reported improved critical thinking; experiencing thoughts that were clearer and more organized; feeling directed towards "higher" and "deeper" truths; and having a deeper recognition of the love that family members held towards them:

"I realised my dad has a lot of respect for me. I realised that because I always used to think he is always criticizing me, sometimes belittling me. And I do so much, "you don't see what I do?" That was my thought before, now I realised he has a lot of respect for me (P4)"

Improved Relationships with Others. Participants experienced improved relationships with others. Some formed new relationships with people who could offer love, understanding and respect; as well as with people who found participants interesting, could "treat me like a normal [expletive] person" while at the same time being sensitive to triggers of past trauma. One participant purposefully sought out new relationships with authentic and honest people. These new relationships often provided a sense of validation, community, as well as a sense of mutuality and comradery around different lived experiences:

"I'm literally just going to hang out with people that are just as[expletive] up as me. That all have a giant load of [expletive] of their own so we're all just [expletive] up together in ways that are really healing and happy and good, because then we can indulge in each other's weird kinks and fantasies and things that come from a lot of our traumas that other people would be scared [expletive] of (P7)"

While new relationships were often a source of strength, one participant began a romantic relationship that was ultimately deemed toxic. A second participant ended a toxic relationship with family members who had inflicted past trauma upon them and did not validate their gender identity. Finally, a third participant expressed now wanting to reconfigure, rather than end a pre-existing, stressful relationship with family:

"*Right now there's my parents, there's my brothers and I'm in the middle. I've always been in the middle, I was always the messenger, the translator, the mediator between my brothers and my parents, I don't want to be in the middle anymore, I want them to talk, I don't want to be there, that's my goal (P4)"*

Similar to what had been reported during their *initial* interviews, participants described how their pre-existing relationships had improved and now felt closer to family members following the challenges that emerged over the last year. Participants also noted that their family dynamics became easier, more respectful, and less characterized by tension and anger; and that they had found new ways of dealing with and understanding conflict within the family:

"I used to get offended [by their father] and I used to get mad, like 'why would you say that? You're not allowed to say that' and I would leave, I wouldn't talk to him. I don't anymore, I just respond, I smile, he laughs back, I laugh back, and I just leave (P4)"

Embracing existing or new activities. Participants continued to align their passions with everyday activities and routines. Specifically, participants described how the first episode of psychosis as well as subsequent challenges they experienced inspired them to use different artistic styles; become inspired by different sources; and create art that delved deeper into areas of everyday life that many tend to feel insecure about or ignore. One participant also experienced greater motivation to pursue activities they were passionate about (i.e., sports) following a second episode of psychosis:

"I had more motivation to run and do sports, I'm not consistent yet. I know that I'm taking breaks but I'm discovering how to work (P1)"

Spiritual and religious growth. Four participants described how the spiritual changes they experienced following their first episode of psychosis were maintained over the course of the year. However, these changes seemed less important to them now that time had passed. While one participant adopted a new religion since the first interview, most participants described continuing to engage in less zealous spiritual practices, instead preferring spirituality that is more grounded in the body and everyday experience:

"I started practicing magic again, which is super good for my mental health because it's something that I've reclaimed. Doing Wicca and Paganism has been a really healing way that I can still connect to magic without it being connected to the same kind of magic that I was doing in my psychosis (P7)"

Engaging with and giving back to other people and communities. Participants described being more likely to engage with, and give back to, communities during their follow-up interview compared to the *initial* interview. Often, they engaged with new communities that reflected the interests and passions they rediscovered following the first episode psychosis. For instance, one participant who rediscovered their passion for art following the episode was now more deeply engaged in arts-based communities. Participants gave back to others by involving participating in new forms of political activism, volunteering with or organizing community-based events; creating community and connections among people with shared lived experience; sharing personal stories about psychosis to help others heal; and offering informal peer support with people experiencing mental health challenges by offering guidance and support:

"I shared it with her because something inside me told me to and she needed to hear my story for her to be able to move on. And she was very grateful that I shared, because I noticed she was very anxious and she just started talking to me, she said everything that was wrong. And I pointed her where to go, what to do, by sharing my story. (P4)"

Objective three: To explore facilitators of PTG

During the *initial interviews*, participants described how their PTG was facilitated by the psychosis itself and the sequalae it brought forth; normative developmental experiences; receiving formal mental health services; using personal and social resources and strategies to deal with adversity; engaging in a meaning making process; and drawing on knowledge and information that could strengthen the areas of growth participants had experienced (Jordan et al., 2020a). Our analysis of *follow-up* interviews developed three themes that encompassed the facilitators of PTG participants drew on since their *initial* interview. These included *personal*

resources; support from people and communities; and traditional mental health services, interventions and supports.

P*ersonal resources.* Participants described how they used pre-existing, strengthened or newly developed personal resources to facilitate PTG. These included being an active, responsible person; having confidence to assert their place among other people and the world; relying on personal strengths to negotiate challenges and affirm the parts of their identity unrelated to their mental health challenges; and defining themselves as survivors:

"I guess realising that there's more interesting things about me than my psychosis. I guess realising that my psychosis doesn't define me as a person and that there's other things that I could talk about in my life that would still fill me up as an interesting person without needing to constantly backtrack and be, like "but this!" (P7)."

In addition, several participants who engaged in art over the course of the year felt that art helped them understand the meaning behind their experiences; express their thoughts and feelings; connect with their inner self; and find ways to heal from their challenges:

"Writing down my experience and seeing it from different perspectives. Right now my thoughts, it's a really big thing to see if my thoughts are true or not, from when I'm believing it's helping me or if it's harming me (P2)"

Participants also described the importance of relying on self-help resources, such as blogs; using strategies that helped them heal from prior traumas; staying away from substances such as alcohol or marijuana; and simply being fed up with and wanting to push back against the limitations imposed by their challenges:

"I did a lot of self-help while I was hospitalised so I learned a lot of ideas. I became aware of myself and other things about humans in general, that were able to help me cope better and to understand things better and have a better expectations in the future" (P3)

S*upport from people and communities.* Many participants described how their changes were shaped by the support they received from loved ones and their involvement with communities centred around art, political activism and shared lived experience. Many

emphasized the importance of having relationships with people who believed in them; were grounded in practical, everyday reality; affirmed parts of their evolving identity; and treated them with dignity and respect. Specific forms of support that were described as important included emotional support (e.g., feeling that people believed in them), instrumental support (e.g., being present during times of crisis) and having the opportunity to disclose and communicate thoughts and feelings. Participants highlighted how in addition to providing such support, others often helped participants identify a deeper meaning and positive aspects about their experiences:

"All these creative possibilities emerging and it was so overwhelming, it was too much at once, I actually had to lie down on the floor just to help me stay grounded, because I was like 'oh my gosh, all these people and they're so awesome and my mom was just like 'do you want Indian food for dinner?' and its super helpful having her around because she helps to remind me, with friends that I meet, one of her first questions is "are they like feet-on-the-ground type people?", and I met someone recently who is kind of into tarot cards and stuff and I'm like 'I don't know if I'm going to go that route'.(P6)"

*Support from traditional mental health services***.** Participants described using and receiving formal mental health services and treatments throughout the course of the year. This may in part due to participants being recruited, and receiving treatment from, an early intervention service for psychosis. For instance, five participants who experienced a new mental health challenge were hospitalized, which ranged from weeks to several months. Despite the restrictions to participants' freedom, the boredom that sometimes ensued from being hospitalized, many felt being hospitalized gave them the time and space needed to rest, bond with others, reflect and heal:

"I had fun with the other patients; I was laughing, I was goofing off. Sometimes it was annoying, when I was trying to sleep there was this other patient who kept saying zero, zero, as he was reading the plaque of the rights - the user rights of [name of hospital] (P2)"

Participants described the importance of taking low doses of medication that could help them deal with their mental health and induced few side effects. In addition, they highlighted

how various services and treatments offered at the service and elsewhere facilitated the positive changes they had experienced since the first interview. Participants highlighted the importance of psychiatrists who actively listened and addressed a range of symptoms associated with their mental health. Consistent with what was described during their first interviews, two participants who received psychotherapy described its importance in supporting their changes. Participants expressed how psychotherapists helped participants understand and become aware of who they are and of their psychological barriers; addressed issues within participants' families; and understand the impact of past trauma on their current mental health:

"And that's really helpful because it helped me to become more mindful and more grounded and present in where I am, and that's definitely one of the things– to uncomfortable sensations, to be like present to it and not just to like push it away or try to like stay really busy. (P6)"

Discussion

This study examined if and how participants who experienced PTG following a first episode psychosis changed following their *initial* reports of PTG. Participants experienced new challenges since the *initial interviews* as well as PTG to their sense of self; relationships with others; everyday activities; and spiritual/religious lives. Participants also became more invested in engaging with and giving back to others and communities. Facilitators of PTG included personal resources; support from people and communities; and traditional mental health services, interventions and supports.

Aspects of PTG were largely consistent with aspects described during the *initial* interviews (Jordan et al., 2019) and with other studies in psychosis (Dunkley & Bates, 2015; Mapplebeck et al., 2015; Slade et al., 2019), although some differences were apparent. Participants described experiencing improved mental health during the *initial* interviews but not during *follow-up* interviews. Perhaps participants who had recovered from their challenges felt

that their past anomalous experiences seemed less relevant to their lives (Davidson & Roe, 2007).

Many participants described how PTG described during the *initial* interviews contributed to PTG later on. This finding is consistent with the "broaden and build" theory which suggests that positive emotions encourage the development of new positive thoughts and skills (Fredrickson, 2004), and suggests that aspects of PTG may influence growth in other domains, and perhaps enhance personal resilience.

Participants became more interested in engaging with and giving back to others and communities during the *follow-up* interview. This finding is consistent with the model of PTG, which highlights how PTG may lead to, and be shaped by, acts of service (Tedeschi et al., 2018); and research showing that people who give back narrative their life stories according to redemption sequences (McAdams, 2013). Alternatively, participants' greater willingness to give back may have resulted from developing a sense of solidarity with others and anger around social justice issues, which may have led to a greater passion in effecting change within participants' communities (Craig et al., 2020).

Although participants reported PTG, some faced new challenges to their mental health since their *initial* interview, suggesting that PTG may be unrelated to mental health problems. This is consistent with studies showing weak relationships between PTG, depression and anxiety (Shand et al., 2015).

Finally, facilitators of PTG were largely consistent across both timepoints. However, participants placed less importance on the role of mental health services, and more importance on community, in facilitating PTG during the *follow-up* interview This highlights the possible diminishing importance of services vis-à-vis communities for some people over time.

Implications

Our findings imply that PTG may change over time and be shaped by life circumstances and the availability of resources including positive, validating relationships; a valued place in one's community; having fundamental human rights; adequate social and material resources; and mental health services. Policy makers, community leaders and activists should continue to address social determinants of health that may lead to a resurgence of psychosis and potential challenges to PTG, including inequality, poverty, and discrimination (Davidson et al., 2005; Rowe & Davidson, 2016).

Our findings do not imply that all people who experience a first episode of psychosis experience PTG. In line with best practices for conducting thematic analysis, we purposefully sampled people who explicitly endorsed PTG to capture as much information about this experience as possible (Braun & Clarke, 2006; 2020). However, there is not enough evidence to suggest that such experiences are common or that our findings are generalizable to most people who experience a first episode of psychosis.

Strengths and limitations

Our study is one of few to examine PTG over time across any adversity, including psychosis, and can therefore help address unanswered questions about PTG. We did not recruit participants until data or thematic saturation was achieved. Saturation was not possible due to our sampling method, and because recruitment until saturation is not advisable when conducting a reflexive thematic analysis. However, our analysis produced a rich account of participants' experiences, which methodologists have argued is a more important goal when using reflexive thematic analysis (Braun & Clarke, 2021).

One limitation of this study was that participants were originally referred to the study by their own treatment providers. This may have resulted in capturing experiences that were

favourable to the perspectives of the treatment team and the omission of perspectives that were critical of the care they received, the medical model, or that fell outside expectations of what clinicians may have believed PTG resembles. A second limitation is the small sample size of the study. While small sample sizes are the norm in qualitative research and provide researchers with opportunities to investigate subjective experiences in greater depth, the sample size may have limited the theoretical generalizability of the findings.

Finally, the experiences of five out of the twelve original participants could not be explored due to study attrition, thereby limiting our knowledge of how the complete pool of participants changed over the course of the study. However, themes from the *initial* interviews were no different among participants who remained engaged or disengaged. Baseline quantitative levels of PTG were also equal across groups.

Future directions

Future qualitative research is needed to unpack how people who experience PTG following the onset of psychosis continue to change over time. Ethnographic approaches may be particularly useful in unpacking the greater contextual factors shaping such changes. In addition, quantitative research examining changes in and predictors of PTG among a larger sample of people with experience of psychosis is needed. Psychometric testing of quantitative measures of PTG (i.e., the PTG inventory) would shed light on the underlying factor structure of such experiences among a larger sample. Future longitudinal research should also examine if rates of PTG varying according to levels of disability experienced. This would help determine if growth is common across the disability spectrum.

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Table 1: Demographic characteristics of participants

	Participants who completed initial interviews	**Participants who completed follow-up interviews**
Variable	**M/SD; *f*/% (n = 12)**	**M/SD; *f*/% (n = 7)**
Age	24.36 (2.78)	23.17 (2.64)
Gender		
Male	5 (45.5%)	3 (50%)
Female	5 (45.5%)	2 (33.33%)
Transgender	1 (9.1%)	1 (16.66%)
Completed high school	11 (91.7%)	6 (85.7%)
In school, receiving training or working	5 (41.7%)	2 (28.6%)
Single relationship status	9 (75%)	6 (85.7%)
Ethnic backgrounds		
Arab	1 (6.25%)	1 (9.09%)
Black	4 (25%)	3 (27.27%)
Chinese	1 (6.25%)	0
Latin American	1 (6.25%)	0
South Asian	1 (6.25%)	1 (9.09%)
White	6 (37.5%)	4 (36.36%)
Other†	2 (12.5%)	2 (18.18%)
Diagnosis		
Schizophrenia-spectrum disorder	6 (50%)	5 (71.4%)
Affective psychosis	6 (50%)	2 (28.6%)
Baseline PTG captured during initial interviews	68.5 (25.41)	58.28 (25.51)

† = Berber = 1, mixed Black and White = 1. Ethnic backgrounds do not add up because some participants could indicate more than one ethnicity in the demographic questionnaire. One participant did not report their gender.