# HOW PSYCHIATRISTS TALK ABOUT THE RELATIONSHIP BETWEEN TRAUMA AND PSYCHOSIS

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**A thesis submitted in partial fulfilment of the requirements of the University of East London for the doctoral degree in Clinical Psychology**

**Word Count: 30587**

**Acknowledgements**

I would first like to thank those who participated in this research for their enthusiasm, time and views. I would also like to thank Dr David Harper for his support, advice and constant encouragement.

I would like to especially thank Natasha whose patience and faith in my ability has sustained me throughout this process. Finally, I would like to acknowledge my mother, Karen who is a constant source of inspiration to me.

## CONTENTS

**ABSTRACT**

In recent years there has been increasing interest in the debate regarding the role of trauma and abuse in the development of distressing experiences labelled as 'psychosis'. However, despite literature reporting a high prevalence of physical and sexual abuse in those diagnosed with psychosis, the aetiology of psychosis has been predominantly constructed as best understood through biomedical or disease models. Research suggests such models are most strongly endorsed by psychiatrists in relation to the categories of psychoses, in particular schizophrenia. These models tend to position life events as triggers of an underlying biogenetic vulnerability, and therefore have implications for psychiatric practices, the identity of those labelled as ‘psychotic’, and the meaning that is attributed to a person's experience of distress.

This study adopted a critical realist social constructionist epistemology to explore psychiatrists' discursive constructions of the relationship between trauma and psychosis using qualitative methodology. Seven psychiatrists with experience working in NHS services were interviewed. Interviewees appeared to draw on psychiatric classification systems to define both 'psychosis' and 'trauma', therefore privileging individual and internal pathology, and limiting acknowledgement of contextual influences on a person's distress. A biomedical aetiological repertoire was consistently drawn upon which constructed psychosis as a brain disorder with psychosocial factors positioned as consequences, or symptoms, of an illness. This reliance upon medical pathological frameworks to define 'psychotic' experiences led to an incompatibility with a view of a person's distress as meaningful and understandable in the context of their lives. Psychiatry's professional alignment with medicine favoured impersonal, neutral and objective accounts of treatment decisions, with the construction of decontextualised individuals warranting interventions targeting the modification of internal biological pathology. Furthermore, constructions that positioned a person as a passive victim of internal pathology, diverted professional attention from how and why people were subjected to abuse and/or neglect. Implications of the study are considered in relations to research and theory, professionals practice and training, and service users.

# CHAPTER 1 - INTRODUCTION

## 1.1. Psychosis

Psychosis is a term generally used in reference to psychiatric diagnoses which assume a person to have lost contact with reality. It is characterised by experiences of heightened sensitivity, unusual experiences (those that are not experienced by others, e.g. hallucinations and unusual beliefs), distress, despair, confusion and disorganization (Read et al., 2004). In psychiatric literature these kinds of experiences are often made sense of with the use of diagnostic categories, such as schizophrenia, which is the most common and considered most severe. However, several other psychiatric diagnoses are considered to be on a psychosis spectrum (Read et al., 2004; Geekie & Read, 2009). The current and most widely used operational definition of schizophrenia can be found in the American Psychiatric Association's (APA) Diagnostic and statistical Manual of Mental Disorder, DSM IV-R, and also the World Health Organisation's International Classification of Diseases, ICD-10 (APA, 2004; WHO, 2010). In recent years it has become increasingly common to use the term 'psychosis' in clinical settings, however it has been less clearly defined than that of schizophrenia (Geekie & Read, 2009; Boyle, 2006). Therefore, much of the research presented in this chapter will be in relation to schizophrenia.

## 1.2. The Debate of Causality in Psychosis

The distress and difficulties often labelled as 'mental illness' are understood in a variety of ways, both within psychiatric services and in society more broadly (Broome, 2007; Harland et al., 2009; Magliano et al., 2011). This is reflected in the enormous range of possible causal explanations of psychotic experiences that have been suggested (BPS, 2000). Despite enormous efforts, it is widely held that the causes of the experiences labelled as 'psychosis' and 'schizophrenia' are not well understood (NICE, 2010). However, there are a number of aetiological models that have been developed in order to understand the possible causes, these broadly consist of; medical or disease models, psychological models, and social models. Each model is defined by particular assumptions regarding the causes of mental distress which in turn have significant implications for; the focus and methods of

causal research; how the individuals suffering mental distress are viewed by professionals and wider society; the significance attributed to 'symptoms' (what they are and what they mean); how and what treatment interventions are provided; and the course and outcome of an individual's distress (Bentall, 2003; Read et al., 2004; Davey, 2008; Harland et al., 2009). Consequently, models of aetiology have particular importance to the field of mental health and psychiatric professionals, none more so than psychiatrists.

There has been a long history of acknowledging the role of life experiences in the causation of distress in those who come to be described as 'mad' or 'mentally ill', this can be seen in ongoing debates which have taken place since the origins of modern psychiatry (Boyle, 2002a). Over recent years there has been a significant interest regarding the role of trauma, in particular physical and sexual abuse, in the distress experienced by those who have received diagnoses of psychosis or schizophrenia (Johnstone, 2011). A key dialectic that is highlighted by this debate is whether,

> 'Madness is a meaningful and understandable response to life circumstances? Or simply the manifestation of a biological based illness, with life events operating, at most, as 'triggers' of a meaningless disease process?' (Johnstone, 2011, p. 101).

In the case of psychosis, certain experiences such as delusions and hallucinations are commonly seen through a biomedical model of psychiatry, as 'symptoms' of an underlying illness or brain disease (Johnstone, 2011; Boyle, 2002a). However, advocates of psychosocial models see such experiences as meaningful, although not necessarily always immediately understandable, in the context of the person's life (DCP, 2011). These often competing positions are based upon assumptions as to the nature of a person's distress and have over time come to be supported by varying types of evidence and complex theoretical networks (Boyle, 2002a; 2011). It is said that these assumptions can be organised according to several oppositions which are reflected in traditional theorizing including individual/social and normal/pathological (Harper, 1996). Despite this debate the understanding of the causes of distress or madness, and in particular psychosis, in mainstream

psychiatric practice are dominated by the individual and pathological poles (Harper, 1996, 1999). For that reason, madness is currently seen as something to do with a person's health and therefore, requires professional 'expert' help sought from doctors and hospitals. This distress being commonly seen as something that is located within an individual's mind, rather than in relationships or the social context (Cromby et al., 2013).

The aim of this chapter will be to examine the systems of knowledge which have developed in relation to both the biomedical and psychosocial models of the distress labelled as psychosis. In particular how; when considering the role of trauma and abuse in the area of psychosis and schizophrenia - a diagnosis which has been referred to as 'the prototypical psychiatric disease' which theorizes according to a biomedical model as arising from individual internal pathology - questions are asked of a set of assumptions upon which modern psychiatry is built (Johnstone, 2011; Boyle, 2002a). Furthermore, by examining the views and attitudes held by psychiatric professionals, and in particular psychiatrists, there will be an exploration of the influence of these systems of knowledge on practices and the consequences for mental health institutions and individuals in distress (Georgaca, 2013; Harper, 1996).

### 1.3. The Construction of Psychosis

Geekie & Read (2009) highlight that categories such as psychosis are ‘essentially contested constructs’, meaning there will probably never be universal agreement in how to define them, let alone what causes them (Geekie & Read, 2009, pp. 7). Much of the mainstream writing and research in this area is based upon positivist empiricist assumptions that an entity 'psychosis' exists whilst debating about 'its' nature (Harper, 1996). Whereas from a social constructionist perspective, such diagnostic categories are considered as one of a number of powerful discourses that construct 'psychosis' and 'schizophrenia' as reflecting a particular reality. Boyle (2002a) defined these discourses as "patterns or regularities in the way we talk or write about particular phenomena, which have certain important effects" (p.207). These patterns are considered to establish or 'produce' and make seem reasonable a particular version of reality (Willig, 2001). In the following section there will be a consideration

of the main discourses that have constructed not only 'psychosis' and 'schizophrenia' as a reasonable version of reality, but also as a brain disease with a biogenetic cause (Boyle, 2002a).

### 1.4. The Categorical Approach

A powerful mechanism that maintains the belief of 'psychosis' and specifically schizophrenia as a brain disease is the consistent presentation of the category 'schizophrenia' as a diagnosable illness that requires professional expertise to identify and modify (Boyle, 2002b). Boyle (2002a) has drawn attention to what Foucault (1976) calls the 'conditions of possibility', 'These being the conditions which made it seem reasonable for psychiatrists' to 'discover' a specific mental disease which explained a wide range of bizarre behaviours', namely dementia praecox later known as schizophrenia (Boyle, 2002a, p. 43). As well as the dominant construct of psychotic illnesses, as 'degenerative biological diseases', and as a result a focus predominantly on biological practices of intervention which require specialist expertise to deliver (Zipursky et al., 2012; Bendall et al., 2011; Bentall, 2003).

It is suggested that by the 1900's, European psychiatry was a well-established medical speciality (Szasz, 1979). However, according to some writers, if physicians wanted to maintain a professional claim to their involvement in madness, it had become a practical necessity to accommodate it into whatever theoretical framework that was being utilised to study physical ailments (Bentall, 2003; Cromby et al., 2013). According to Szasz (1979), the discovery of the syphilitic origin of paresis allowed the scientific confirmation of the somatogenic hypothesis first asserted by Griesinger in 1845 that; 'persons whose brains are abnormal are likely to exhibit behaviour commonly judged abnormal' (Szasz, 1979, p.6; Cromby et al., 2013). It is posited that this allowed the emergence of what we now come to think of as the role of psychiatry as being the diagnosis, study, and treatment of mental diseases, which as described by Szasz (1979) are the, "abnormal biological processes within the patient's head manifested by the psychological and social "symptoms" of his illness' (p.6). Such hypotheses were based upon Cartesian dualism that had become prevalent in Western psychiatry. This idea holds the mind as distinct from the brain

which is seen as a purely material and deterministic neurological mechanism (Scull, 1979; Bracken et al., 2012).

Following the development of the somatic hypothesis it began to dominate understandings of madness and informed Emil Kraeplin’s, Eugen Bleuler's and Kurt Schneider's construction of schizophrenia (Boyle, 2002a). The early conception of the term Schizophrenia was first suggested by Eugene Bleuler as a replacement for the idea of 'dementia praecox' originally proposed by Emile Kraeplin (Jablenski, 2007). Based upon, at the time, reasonable assumptions that a similar disease process as studied in internal medicine might apply to people labelled as mad, Kraeplin developed the idea that there was a 'discrete and discoverable number of psychiatric disorders, and that each disorder will have its own typical symptom picture' (Bentall, 2003, p. 13).

Subsequently the schizophrenia construct, as well as the categorical approach, have been developed and refined in Western psychiatry through the technology of psychiatric classification systems, in particular the DSM and ICD in their numerous incarnations (APA, 2004; WHO, 2010; Boyle, 2002a). Key to the modern DSM is the view that distressed individuals are acted upon by impersonal forces, usually biological dysfunction, and therefore their experiences are not meaningful or intelligible (Jacobs & Cohen, 2010; Boyle, 2011). Thus it is suggested that the reification of the diagnostic category 'schizophrenia' has had profound implications upon the search for causal explanations in that it is incompatible with the acknowledgment of a person's life story (Jacobsen & Cohen, 2010; Sarbin, 1991). Furthermore, it is claimed it has led to causal research, conducted within positivist empiricist research paradigm, to be based upon the assumption that those assigned to the 'schizophrenia' category have something in common which will be absent in individuals considered 'normal' (Bentall, 1993). As will be discussed in the next section, if in fact those assigned to the 'schizophrenia' category have no more in common than a label, then a search for something of aetiological significance is likely to fail (Bentall, 1993; 2003).

### 1.5. The Validity of 'Schizophrenia'

During the 1990's, the concept of schizophrenia came under increasing scrutiny via the systematic establishment that such categories demonstrate poor reliability and validity[1] (Bentall, Jackson & Pilgrim, 1988; Read, 2004). A key argument pertaining to validity has centred on the assumption that 'psychosis falls into discrete categories such as schizophrenia' (Bentall, 1993, p. 227). By applying the concept of 'schizophrenia' to capture a wide range of behaviours and experiences, a problem arises in that rarely all are identifiable when observing an individual (Read, 2004). Read (2004) points out that to receive a diagnosis of schizophrenia using the DSM-IV revised version, recently replaced by the DSM-V (APA 2000; 2013), a person needs to be assessed as meeting two of five 'characteristic symptoms'. This allows for 15 ways by which two people can meet the diagnostic criteria without sharing a common 'characteristic symptom'. This has led critics to suggest it is a disjunctive category and therefore 'scientifically meaningless', as Bentall (1993) states, this has obvious implications for aetiological research relying upon it to group individuals according to common characteristics (Read, 2004)

Also of significance to aetiological claims, Boyle (2002a) highlights a key problem for 'schizophrenia', being how 'behaviours and experiences have been interpreted as symptoms or signs of schizophrenia according to no clear set of rules or procedures', and furthermore, how the use of the term 'sign' has been used in a way that is significantly different from its use in medicine (p. 211). This is important given a key feature of a 'sign' in medicine is that it refers to a level of phenomena which can be independently observed by others (e.g. a measure of blood sugar), however, it is claimed that no such 'sign' exists for 'schizophrenia' (Cape et al., 1994; Boyle; 2002a). In fact, in the case of schizophrenia, it is often used interchangeably with the term 'symptom', which refers to subjective complaints, to give a sense of such attributes being objectively assessed (Boyle, 2002a). Goffman (1961) has cautioned that psychiatry has relied overly on symptoms rather than 'signs', which raises questions as to their 'expert' understanding in this field.

[1] Systematic reviews have been produced by a number of authors including; Boyle (2002a) and Bentall (2003).

Therefore following the pragmatic development of the schizophrenia category, the possible heterogeneity of those considered to fall within the schizophrenia category, as well as the absence of pathognomic signs; has led to widely held concerns that much of the research based upon an assumptions of commonality between people with the schizophrenia diagnosis, is significantly flawed (Cape et al., 1994; Bentall, 1993). However, the influences of the biomedical model assumptions of schizophrenia aetiology have had significant effects upon research and subsequently clinical practice (Boyle, 2011).

### 1.6. The Influence of Biomedical Assumptions on Aetiological Research

As illustrated, the drive to classify and group madness has led to the construction of what some believe to be a scientifically meaningless category, 'schizophrenia'; and to the assumptions its causes will be best understood through biomedical or disease models of aetiology (Read et al., 2004). Szasz (1960) suggests that 'this position implies that people cannot have troubles – expressed in what are now called “mental illnesses” - because of difference in personal needs, opinions, social aspirations, values, and so on'. In fact that all 'mental illnesses' are attributed to physicochemical processes which will be discovered by medical research, that 'mental illnesses' are basically regarded as no different than all other diseases (p.113). Therefore, this model allows the re-designation of social problems to medical ones, with an inherent assumption that the distressed person will require help from a suitably qualified professional in order to manage their distress (Moncrieff, 2011). It is claimed that the institution most invested in such a category is psychiatry, as it provides legitimation for its approaches to treatment, as well as preserving its status as a medical profession (Boyle, 2002a; Pilgrim, 2002, 2007; Moncrieff, 2011).

Over the past century, the biomedical versions of psychosis and schizophrenia, and madness in general, have significantly influenced the direction of research, practice and public views (Kingdon & Young, 2007). However, despite attempts to determine the causal role of biology, the evidence does not point to any single cause (NICE, 2010). In fact, Bentall (1993, 2003) highlights that there have been attempts to link schizophrenia with virtually every brain region or neurotransmitter via every advance in brain imaging. Yet the genetic, neurophysiological and neurochemical

abnormalities that have been found to be associated with the diagnosis of 'schizophrenia' are 'so diverse and so nonspecific that they provide further evidence against the existence of a single, discrete 'schizophrenia disease entity', with some researchers suggesting there is sufficient evidence to reject the Kraepelian paradigm (pp. 229) (Craddock & Owens, 2005).

Despite this, Boyle (2002a) proposes that it is not surprising credibility of the biomedical assumptions of schizophrenia have been sustained so widely given the variety of 'scientific' and 'medical' discourses which contribute to this version of reality (Burr, 1995). It is stated that a particularly significant discourse has been through the use of an empiricist repertoire, which has systematically offered a variety of 'objectively' supported hypotheses about brain biochemistry and pathology, and discoveries of genes that predict susceptibility. As well as leading to the generation of vast amounts of data to support these hypotheses (Boyle, 2002b; Kirk and Kutchins, 1992; Broome et al., 2005; Kety et al., 1994; Craddock et al., 2005; Seeman & Kapur, 2001; Shenton et al., 2001;Rujescu & Collier, 2009; Bentall, 2003; BPS, 2000; Nurnberger & Gershan, 1992, Weinberger, 2005; Sullivan & Kendlar, 2003; Sullivan et al.,2000). Boyle (2002a) also draws attention to the continual evocation of a narrative of scientific progress, through which an impression of gradually moving toward the discovery of the purported biogenetic vulnerability is always around the corner but currently out of reach. Such a discourse is highlighted by Kety's (1974) famous remark 'if schizophrenia is a myth it is a myth with a strong genetic component' (p. 691). However, a number of critics suggest that it is widely acknowledged that there is no direct evidence to support any such claims[2] (Bentall, 2003).

So despite lacking consistent empirical support, the biomedical model continues to support an extensive scientific network which makes apparently reasonable claims as to the biological basis of 'schizophrenia'. In fact, it is levelled that the reification of this biomedical approach has led to junior psychiatrists and trainee psychologists to adopt a biomedical model by assumptions of its truth (Kemker & Khadavi, 1995;

[2] Systematic reviews can be found elsewhere, e.g. Boyle, 2002a; Read et al., (2004).

Harper, 2013). However, as will be explored in the following sections, support for this model is far from monolithic (Harper, 2013).

### 1.7. The Role of 'Trauma' in People's Experiences of Psychosis

The previous sections have explored how assumptions of a medical model which underlie the DSM and much of psychiatric practice, view the experiences categorised as psychosis and schizophrenia as meaningless manifestations of internal pathology and have implications for aetiological research (Boyle, 2002a; Johnstone, 2011). Despite lacking empirical support it is suggested the reductionist 'biogenetic' paradigm, has prevailed in mental health services and research, and it is widely espoused that it has prevented advances in understanding of psychosocial causes of mental health problems (Pilgrim, 2002; Johnstone, 2011; Boyle, 2011, 2002; Read, 2004). However, this model has not existed unchallenged. In fact there has been significant advocation that both the form and the content of the experiences that are labelled psychosis and schizophrenia are 'systematically, meaningfully and inseparably related to social context and life experience' (Boyle, 2011, pp 35). Such a challenge to the idea of that schizophrenia as a primary biological disease, should not be considered a parallel challenge to the reality that people can engage in behaviours that others might find to be bizarre, crazy, insane or irrational (Sarbin, 1991; Read et al., 2009).

As with the biomedical model, there has been a rich theoretical and discursive network develop around this position (Read et al., 2004). For several decades there has been much controversy and inconsistency surrounding this area, in particular regarding the responsibility of parents for the madness of their children (Coulter & Rapley, 2011). In the late nineteenth century, Freud's 'seduction hypothesis', later revised to the 'oedipus hypothesis', claimed reports of sexual experiences were manifestations of fantasies created by children, as opposed to actual experiences (Strachey, 1962; Geekie & Read, 2009). Such an influential theory is said to, contributing to an assumptions that abuse disclosures by 'psychotic' patients often represent 'content' of delusions, and should not to be engaged with (Bentall, 2003).

During the 1960's and 70's however, R.D Laing, amongst others, wrote extensively with a focus upon the families of those labelled as schizophrenic. He hypothesized

that the unwanted and socially unacceptable conduct labelled as 'schizophrenia' was an understandable response to family conflict, and therefore socially intelligible (Laing 1960, 1669; Bentall 2003; Coulter & Rapley, 2011, p.161). This represented a shift to viewing 'pathology' labelled as 'schizophrenia' as residing in the relationships between family members, as opposed to object relations theorists view as residing in intrapsychic pathology (Laing 1960, 1969; Lidz & Lidz, 1949; Coulter & Rapley, 2011). This view therefore advocated interventions that were focused upon social context. However, the potential impact of these theories was limited by a discourse of family blaming which led to avoidance of suggesting any causal roles of families (Johnstone, 1993). Terkelson (1983) has claimed this avoidance resulted in many family theorists failing to address aetiology completely, and therefore sacrificing conceptual clarity.

In recent years controversy around this debate has re-emerged, but in the form of whether trauma and abuse play a role in the development of 'psychosis' (Read et al., 2004; Johnstone, 2011). The controversy regarding this debate has been further amplified by the link with child sexual and physical abuse.

### 1.7.1. Summary of recent findings

Put simply, there is increasing evidence that the experiences of people labelled with psychosis can be a reaction to traumatic experiences (Johnstone, 2011). Much of this recent evidence has focused upon people categorised under the label 'psychosis', with the assumption that this allows greater explanation of individual experiences and therefore, a focus upon meaning (Read et al., 2004, 2005). However, as with the term 'schizophrenia', there is growing concern regarding the uncritical use and reification of the term 'psychosis', due to its increasing use as alternative to 'schizophrenia' (Boyle, 2006; Johnstone, 2011). Particularly due to the risk it simply assimilates and perpetuates the problems of the 'schizophrenia' concepts including the 'privileging of biological over psychological and social theories' (Boyle, 2006, p.2).

Notwithstanding these concerns, a large body of research has accumulated leading to the increasingly widespread acknowledgement of a relationship between early adversity and psychological difficulties of all types in later life (Shafer & Fisher,

2011). Central to these developing ideas has been research focused upon, what are considered traumatic experiences in childhood and adolescence, including sexual and physical abuse, and emotional abuse and neglect (Larkin & Read 2008; Read et al., 2009, Read, et al., 2008, Harrop & Trower, 2003). This research has revealed the prevalence of history's of physical and sexual abuse in people who have received a diagnosis of psychosis, as well as links to the form and content of the person's psychotic experiences (Bendall et al., 2008; Read et al., 2005). Abuse is considered a very common problem with estimates that in the general population around 11% of children are sexually abused (CSA) and 24% of children physically abused (CPA) (May-Chahal and Cawson, 2005). In comparison, in a review of 46 studies, totalling 2604 female inpatients and outpatients, most of whom were diagnosed with psychosis, it was found that the majority of female patients (69%) report either CSA (48%) or CPA (48%), with 59% of male patients reporting suffering either CSA (28%) or CPA (50%), suggesting significantly higher rates in psychiatric populations (Read et al., 2005). These findings are supported by findings from a large sample of patients from the AESOP study, which reported finding that females diagnosed with first episode psychosis (FEP) where twice as likely than female controls to have experienced child physical or sexual abuse (Fisher et al., 2009). However, these findings have often been criticised for their reliance upon self-report methodology and therefore concerns as to the reliability of reports given by patients (Johnstone, 2011).

The recent growing interest in this area is illustrated by the completion of several large-scale general population studies, a review in 2009 identified 11 in total (Read et al., 2009). One such study of a cohort of 2759 individuals taken from all notified cases of sexual abuse over a 30-year period in Victoria, Australia - therefore not relying upon self-report (Cutajar et al. 2010; Bendall et al, 2011). They were then matched with the Victorian Psychiatric Case Register (VCPR) for any psychotic disorder they received as adults. The findings indicated significantly increased odds of being diagnosed with psychosis (Odds ratio = 2.1) and schizophrenia (2.6) if they had histories of experiencing CSA compared with age and gender matched controls. Additionally observed was an association with the severity of abuse, such as more than one perpetrator, and increasing risk of developing psychotic syndromes

(Cutajar et al., 2010). Similar, 'dose response relationships' were identified in a prospective study carried out in the Netherlands, with 'mild abuse' having an odds ratio of 2.0, but 'severe abuse' being 48.4 (Read et al., 2009; Shafer & Fisher, 2011; Janssen et al., 2004). Furthermore, both anecdotal reports and research finding have highlighted a link between the content of 'psychotic' experiences and the actual experiences of childhood abuse (Johnstone, 2011, Herman, 1992; Larkin et al., 2003).

### 1.7.2. Critique of the 'trauma' discourse

As suggested before, these finding challenge key assumptions upon which the biomedical model is built and therefore modern psychiatric practice. However, whilst this trauma focused research may have brought psychosocial causes back to mainstream attention, there is concern that it too is resulting in a subtle 'de-emphasis of the importance of the environment' (Boyle, 2006). Given that the construct of psychological trauma is now embedded within Western culture there is concern it obscures the complexity of peoples' experiences (Boyle, 2006; Johnstone, 2011). Furthermore, its refinement through the technology of psychiatric classification systems in relation to the increasingly diagnosed Post-Traumatic Stress Disorder; in which an 'objective' scientific conceptualisation of the world is privileged; and in which a dualistic concept of a person is dominant (Bracken, et al., 1995; Summerfield, 1995, 2001; Pupavac, 2001). This leads to an individualistic and pathological framework for understanding experiences being evoked, and therefore labelling the individual as 'damaged' thus taking attention away from the abusers, and the societal and cultural systems that sustain these abuses (Patel, 2011; Jacobs & Cohen, 2010; Johnstone, 2011).

Furthermore, there is significant concern that there are various discursive repertoires which have resulted in mental health professionals, in particular Clinical psychology and Psychiatry, avoiding confronting such causes of distress. It is posed that acknowledging context is not intentionally avoided but is result of assumptions embedded in mainstream psychology and psychiatry theory, research, language and practice (Boyle, 2011). These being those advocated by a biomedical model which views individuals in a decontextualised fashion, 'whose behaviours, cognitions and

emotions are best accounted for by reference to their brain and minds' (Boyle, 2011, p.34). As a consequence the significance of findings implicating non-biological causal factors are often downplayed through several rhetorical devices (Boyle, 2002b). First, of which being the findings are correlational and therefore provide no evidence of a causal relationship (Johnstone, 2011). Second, for not providing evidence of 'mechanisms' that may help to understand how trauma may lead to psychosis (Boyle, 2011; Johnstone, 2011). Although there have been, several speculative psychological models developed in an attempt to explain the relationship between traumatic experience and the development of a psychotic experience (Garety et al., 2001; Morrison, 2001; Bentall et al., 2001). These have been dominated by cognitive theories, which have been criticised for attributing distress as arising from biases, deficits or defects in the processing of information and stimuli (Cromby et al, 2013). Boyle (2011) draws attention to how such models, strongly advocated by mainstream Clinical Psychology, have contributed to the obscuring of the role of life experiences in distress by focusing upon intrapsychic attributes, usually psychological deficits or abnormalities, to explain experiences associated with psychosis. These models therefore provide a rationale for focusing research and interventions upon an individual as opposed to upon their lives or context.

Finally, and of particular importance due to its widespread advocation within mental health services; is the claim that the bio-psycho-social model or more specifically one of its most commonly referred to derivates - the 'stress-vulnerability model' - is in fact an illusion of balance and integration of models (Engel, 1980; Zubin, 1977; Read et al., 2004; Pilgrim, 2002). This model has become popular given its acknowledgment of the role of social stressors as triggers of a vulnerability, a vulnerability which over time has become synonymous with the notion of an underlying biogenetic vulnerability (Read, 2005; Coulter & Rapley, 2011). However, the original stress vulnerability model stated that vulnerability can be acquired and that this can be ‘due to the influence of trauma, specific disease, perinatal complications, family experiences, adolescent peer interactions, and other life events that either enhance or inhibit the development of subsequent disorders' (Zubin & Spring, 1977; p.109). By relegating the role of contextual factors to 'triggers' of an

existing vulnerability, the primacy of biology is maintained with aversive environments being downplayed (Read, 2004; Boyle, 2002, 2011).

In spite of these concerns it is clear research, focused upon the lives of those experiencing distress labelled as 'psychosis', has provided a challenge to the traditional biomedical model, and stimulated much debate in psychology and psychiatry. It has raised questions regarding; the logical status of mental illness; the intelligibility of madness; and the role of institutional care delivered under a dehumanising biomedical regime (Pilgrim, 2002). Consequently, psychiatric professionals exist in an arena where the aetiological ideas that inform their professional practice are currently contested and are far from monolithic (Harper, 2013). The following sections explore how this debate has influenced the aetiological models held and drawn upon in modern psychiatric practices, and whether the taken-for-granted ways of speaking, theorizing and practicing associated with mainstream psychiatry are identifiable (Boyle, 2011).

### 1.8. The 'Attitudes' of Psychiatric Professionals

Scull (1975) proposes that experts, through their power to legally label have the effect of focusing, defining and institutionalising a deviant's status, and differ from the layman in their authority to define the existence of a problem and how it should be managed (Foucault, 1976). Possibly the most important of these in the field of mental health are psychiatrists, who are strongly associated with providing scientific basis for their view of madness. As explored, it appears that there is a complex relationship between the various aetiological versions of psychosis and schizophrenia; each of which are maintained by a complex discursive network (Harper, 1996). Therefore there is a diversity of available perspectives for psychiatric professionals to negotiate in modern practice. There have been a number studies exploring how practicing psychiatrists construct 'psychosis' with a particular focus on 'schizophrenia', and the influence these constructions have upon their practice and the well-being of patients presenting with psychotic experiences (appendix 1 for search terms).

A questionnaire study to ascertain the beliefs about schizophrenia aetiology and prognosis of 119 members and fellows of the Royal College of Psychiatrists,

employed by the South West Regional Health Authority, was conducted by Cape *et al.* (1994). Among the findings was an indication of 'general clinical impression' being heavily relied upon by practising clinicians during diagnosis, with Schneiderian first rank symptoms endorsed as most useful when testing this, 'clinical judgement' (Cape et al., 1994). This was opposed to the use of 'tight' operational diagnostic criteria such as that provided by the DSM-III (APA, 1980). Also found was how organic aetiological models of schizophrenia including brain pathology, genetic predisposition, and neurotransmitter dysfunction, were most strongly endorsed. Cape *et al.* (1994) attributed these finding to biases in research literature towards finding biological causes of schizophrenia, as well as psychiatrists' training being largely based upon a biomedical model.

Cape *et al*. (1994) indicated biological aetiologies were strongly associated with decision to treat with medication, whereas psychiatrists with strong beliefs of psychosocial causes were more likely to opt for non-medical treatments e.g. psychotherapy. It was posed that it is significant that schizophrenia has no external or objective criteria against which it can be validated, given that it appears the diagnostic process relies strongly upon the clinical impression of the professional, therefore leaving its definition and understanding subject to the prevailing political and social climate (Cape, et al., 1994). Similar findings were seen in a questionnaire study of 79 medical students finding they generally considered both psychological and biological factors when considering aetiology and treatment, but in the case of schizophrenia strongly endorsed a biological aetiology (Brog & Guskin, 1998).

Recent research indicates a possible shift in aetiological attitudes held. Kingdon *et al*. (2004) surveyed members of the Royal College of Psychiatrists with a questionnaire comprising of two existing attitudes to mental illness survey instruments, supplemented with questions about schizophrenia and its management. Of 2813 (45% total contacted) respondents, 53.5% believed causes of schizophrenia were a balance of both social and biological factors, compared with 46.1% stating primarily biological causal factors.

However, in contrast, the primacy of a biomedical model aetiological understanding of schizophrenia was demonstrated by Harland *et al*. (2009). A sample of psychiatric

trainees from South London and Maudsley NHS completed a questionnaire to measure the use various aetiological models such as, behavioural, biological, social constructionist etc., drawn upon to understand clinical material. The results suggested that particular models were linked to specific disorders, ‘to the extent that some disorders may be regarded by trainees as paradigmatic exemplars of the explanatory power of a given model’ (Harland et al., 2009, p. 973). Given among the examples was that 'schizophrenia has a biological aetiology and should be investigated through biological research', whereas generalised anxiety disorder should be seen from a cognitive behavioural perspective and treated through challenging and restructuring 'maladaptive thoughts' (Harland et al., 2009, p. 974). This possibly demonstrates that aetiological assumptions are not consistent across psychiatric diagnoses and therefore that varying causal factors are acknowledged. Additionally, the models that psychiatrists hold have an influence upon not only treatment but also the direction of further research.

Magliano *et al*. (2011) used a self-report tool to assess the views of schizophrenia held by 5th and 6th year medical students at the University of Naples. In line with the previous findings the medical students strongly endorsing heredity as causal in schizophrenia. However, interestingly they found that 69% of students also endorsed stress and 45% of students endorsed psychological trauma, as causes of schizophrenia. It was suggested this represented the application of a distorted vulnerability-stress model by medical professionals. Thus allowing the acknowledgment of psychosocial trauma and stress in the aetiology of those diagnosed with schizophrenia, whilst simultaneously maintaining the primacy of a biogenetic understanding (Magliano et al., 2011).

These studies showed varying influence of age, experience and academic experience of the psychiatric professionals assessed. Cape *et al.* (1994) found a correlation between older, more experienced psychiatrists giving greater emphasis to the psychological aetiological factors, possibly suggesting that the training of the older psychiatrists took place when psychological factors were more popular, alternatively that their experience has influenced their understanding. Whereas, Kingdon *et al*. (2004), indicated consultants favoured primarily biological causation when compared with trainees, and those qualified 10 – 20 years also marginally

favoured primarily biological aetiology (49.9% compared with 49.8%). However in general, the sample appeared to favour a balance between social and biological causes. It is possible these findings are a reflection of the continuing debate that is taking place with the psychiatric profession regarding the contested nature of aetiology, as well as illustrating institutional training biases, combined with the increasing availability of alternative theoretical models (Kingdon et al., 2004).

Also demonstrated by several studies was the relationship between aetiological explanations of schizophrenia and the construction of people labelled as 'schizophrenic'. It was indicated that viewing causality as biogenetic led to patients behaviour being positioned as unintentional and uncontrollable, for which they were less blame when compared with diagnoses considered as resulting from psychosocial causation, such as personality disorder (Magliano et al., 2011). However, simultaneously biogenetic causation led to an increasing stigmatization with the patient being seen as unpredictable, dangerous and chronically ill. Whereas, when the aetiology of schizophrenia is constructed as an individual's reaction to problematic life events and circumstances, recovery is seen as possible through improving environmental factors (Magliano et al., 2011; Miresco & Kirmayer, 2006; Mukherjee et al., 2002). These finding possibly represent the persistence of the mind-brain dualism in professional mental health, highlighting that medicine has become accustomed to thinking about human distress, and responsibility and intentionality in dualistic terms, often at the expense of acknowledging culture and context (Miresco & Kirmayer, 2006; Thomas & Bracken, 2011).

### 1.9. The Influence upon the Public

It has been demonstrated that the models of aetiology which are drawn upon to 'educate' the public, have permeated contemporary culture, and are linked to the way people speak about their experiences, as well as how those suffering from mental health problems are viewed (Georgaca, 2013). There has long been an assumption that adopting a 'mental illness is just like any other illness' position, would encourage the general public to transfer their non-stigmatizing attitudes of somatic illness to that of mental illness (Sarbin & Mancuso, 1970). However, attempts to equate 'mental illness' with other medical disorders through biological

explanations have been shown to reduce blame, but provoke harsher behaviour toward a person with mental illness (Mehta & Farina, 1997). Additionally, findings of a study conducted in Germany which interviewed samples of the general public at two time points, 1990 and 2001, showed increased endorsement of biological attributions to aetiology over this period paralleled increased public rejection of people diagnosed with schizophrenia (Lopez-Ibor, 2002). An explanation is that this 'harsher behaviour' may be the result of individuals with 'mental illness' being viewed as physically distinct - 'almost a different species' (Corrigan & Watson, 2004). In addition, biological aetiological arguments may strengthen dangerousness stereotypes, suggesting they are unpredictable and violent (Read & Law, 1999). In contrast, the use of psychosocial explanations that acknowledge environmental stressors and trauma, have been shown to improve the image of people suffering from 'mental illness' and reduce the fear of the individuals (Morrison & Teta, 1980; Read & Law, 1999).

Therefore, it can be seen that, far from being a monolithic view about schizophrenia, there appears to be diversity in the views of psychiatrists regarding causation and treatment (Harper, 1999). It is clear that the attitudes held by professionals can greatly influence the well-being of people receiving the label of psychosis with the research indicating influences on diagnosis, treatment approaches, and attributions regarding intentionality and responsibility of behaviour (Tiffin et al., 2009; Cape et al., 1994, Patel, 2003; Patel, 2004). It too can be seen that the aetiological model held, particularly by professionals, have a significant impact upon how people who receive a diagnosis of psychosis are treated, managed and viewed by the public and professionals. Where it appears understanding based upon biomedical assumptions appear to have remained dominant.

### 1.10. Critique of Research

So far, as seen above, studies that focused upon investigating the 'attitudes' and 'views' of psychiatrists, have relied upon a mainstream positivist epistemological position to research and the closely aligned assumptions of cognitivism (Willig, 2001). Several of these assumptions have come under significant scrutiny from a social constructionist epistemological perspective (Edward & Potter, 1992).

Stevens and Harper (2007) suggest there are ‘fundamental epistemological difficulties with the notion that responses to lists of statement are unproblematically transformed into inferred mental constructs like beliefs or attitudes' (p.6). However, it is assumed that questionnaires or vignettes objectively access either; 'attitudes', that is how the psychiatrists feel about objects (schizophrenia) and events (diagnosis) in the social world; or the 'attributions' that have been made by psychiatrist such as how they account for their diagnostic actions. Fundamental to this is the assumption that the object, in this case 'mental disorders' and in particular 'schizophrenia', is itself consensual - that is that these objects are not disputed (Willig, 2008). Therefore, 'people agree on what it is they are talking about, but they disagree about why it happened (attributions) and whether or not it is a good thing (attitudes)' (Willig, 2008, p. 94). However, this view is challenged by social constructionists who argue that these are in fact themselves aspects of the discursive construction of the object itself. Therefore, it is not participants’ attitudes and attributions toward 'schizophrenia' (social object) or the diagnostic process or aetiological formulation (social event) that differentiates them from each other. Rather it is the way in which they construct the object or event itself, primarily through language (Willig, 2008). This critique is particular pertinent when considering the constructs of 'psychosis' and schizophrenia', which as has been demonstrated are widely contested.

Willig (2008) describes a further key assumption of such research, and cognitivism, is that the research process is facilitating access to relatively enduring and stable cognitive structures, which process information in predictable ways. As a result much of this research is based on the assumptions that beliefs, attitudes, and attributions remain stable from day to day and context to context. However, research conducted from a social constructionist epistemology conceptualizes language as productive and performative, hence the views that are expressed in these pieces of research are seen as 'dependent upon the discursive context within which they were produced', therefore beliefs or views expressed may vary dependent upon who the conversation is with as well as its aim (Willig, 2008, pp. 95; Burr 1995). Therefore, it is argued that these are prone to a social desirability bias by which participants tend to answer in accordance with social norms rather than stating real attitudes (Rose et al., 2003).

### 1.11. Social Constructionist Informed Research

However, despite this body of positivist, DSM-informed and largely quantitative based literature, there is an increasing number of qualitative studies exploring the productive nature of language in relation to a variety of psychiatric constructs and practices. From a social constructionist perspective, the assigning of people to categories such as psychosis or schizophrenia, is considered a process of transforming a person's experiences to symptoms of a disorder followed by attributing a disorder to this person as an explanation of the experiences described (Georgaca, 2013). As opposed to an objective act of discovery of a pre-existing entity which resides inside the person and manifests itself in symptoms (Georgaca, 2013; Boyle, 2002a). Therefore, several studies have focused on the use of diagnostic discourse in psychiatric services and its role in constructing social reality.

Qualitative research has demonstrated how the assigning of a diagnosis can lead to a person's distress and difficulties being reformulated based upon biomedical assumptions (Barrett, 1996; Georgaca, 2013). A conversation analysis of 32 consultations between psychiatrists and patients who had received diagnoses of either 'schizophrenia' or 'schizoaffective disorder', demonstrated how patients frequently 'actively attempted to talk about the content of their symptoms' (McCabe et al., 2002, p1150). However psychiatrists avoided answering questions indicating a reluctance to engage with concerns, instead they selectively focused upon systematically assessing frequency and severity of symptoms in relation to diagnostic criteria (McCabe et al., 2002). Such findings suggest interactions between psychiatrists and patients are defined by diagnostic classificatory systems such as the DSM-IV, and as such, pathology frameworks transform behaviour or expressions of distress into symptoms that are either present or absent (Jacobs & Cohen, 2010; Boyle, 2002a).

In a Norwegian ethnographic study of 15 patients and 21 psychiatric professional in a psychiatric unit for young adults diagnosed with schizophrenia, Terkelsen (2009) demonstrated how psycho-educational treatment programmes informed by biomedical psychiatric assumptions led to patients adopting biomedical explanations for their experiences. In addition they assumed responsibility for looking after

themselves through the constant self monitoring of their condition and adherence to medication plans. Although, based upon field notes as the main method of data collection - and therefore open to the influence of the researchers' background knowledge in the construction of the notes - it illustrates the influence of modern psychiatric treatment practices and technologies, such as diagnosis, upon the explanation of a distressed person's subjectivity and experiences (Wolfinger, 2002; Georgaca, 2013).

Other qualitative research has been conducted with a focus upon how diagnosis and classification inform professional discussions and practices, with a particular focus upon case formulations during team meetings and discussions.

A narrative analysis of team meetings in a geropsychiatric unit demonstrated how professionals appear unaware they engage in clinical reasoning and decision making through a constructive process (Crepeau, 2000). During this process team member present often competing views, many of which contain themes such as, expected 'sick roles', and moral tales. Griffith (1998) performed a thematic analysis upon transcripts of team meetings during which community mental health teams processed referrals. They described how differing discursive repertoires were made available to various professional disciplines based upon educational backgrounds and 'claims to disciplinary knowledge', e.g. medical versus non-medical professionals (Griffith, 1998, p. 697). These repertoires often lead to contrasting problem conceptualizations and treatment recommendations within a team. These studies appear to support the findings of a discourse analysis of verbal summaries made during psychiatric case summaries highlighting competing conceptualizations organised by two main narratives; biomedical accounts which construct patients as passive sufferers of a biochemical imbalance and support medical interventions, often in the form of medication; whereas on the other hand is a 'social accounts' which construct patients as an active agents with beliefs and intentions, and locates problems in the personal and social context of the individual, advocating interventions focused at a contextual level (Soyland, 1994, p.113; Georgaca, 2013).

The research presented here demonstrates how the processes of diagnosis and the formulation of aetiology, is negotiated through the range of theoretical

understandings, and is contested within and between professional disciplines. These variable and often competing conceptualizations are influenced by a number of factors including professional training and the power of particular professional disciplines (Craven & Coyle, 2007; Boyle, 2002a; Georgaca, 2013). Furthermore the way mental health professionals talk is important in the construction of a patient's identity, e.g. a passive sufferer of biochemical imbalances. Additionally how they lay claim to particular identities, as part professional groups, with claims to specific forms of expertise e.g. psychiatrists have expertise in diagnosis (Soyland, 1994). It can also be seen that these understanding of a person's distress also have various implications for professional action that is taken regarding interventions - this will be discussed in the next section.

### 1.12. Clinical Implications

As explored, although there are variable discourses drawn upon when conceptualising a patients experience of distress in mental health services, there is an apparent dominant biomedical construction when considering the aetiology of 'psychosis' or 'schizophrenia'. Such a position has implications for those whose distress may be understandable in the context of adverse life experience, given that through a biomedical narrative experiences are seen as 'meaningless symptoms of an underlying mental illness and therefore not to be engaged with' (Georgaca, 2013; Boyle, 2002a). Harper (1999) suggests that the treatments offered by psychiatric 'experts' to 'effect change' in the 'symptoms of psychosis' themselves are based upon certain assumptions as to the aetiology of psychosis (pp.11). This can be observed in how a 'disease centred model' has significantly influenced the how psychiatric services approach the clinical treatment of people who receive diagnoses of 'psychosis' (Bentall, 2003; Moncrieff, 2011). Antipsychotic medications are widely used as the first line treatment for virtually all forms of acute psychosis (Davis et al., 1980). This is despite the many serious toxicities associated with the medications, with between 20 and 25% of people who take typical antipsychotic medication developing disorders of motor movement such as tardivedyskinesia (Gelenberg, 1996). Bentall (2003) highlights that, despite the serious side effects and a substantial minority who do not gain any benefit, there has been little consideration of drug-free strategies for managing symptoms by modern psychiatric services.

Similarly, Read *et al.,* (2004) claims the dominance of a biomedical model has impeded the discussion in psychiatric services of what is going on in people's lives, in their family relationships and the societies in which they live. Read *et al*. (2007), suggests this has led professionals failing to ask about traumatic life experiences in up to 69% of cases, despite patients expectations to be asked (Read et al., 2006).

A number of qualitative studies have highlighted the central role of a biomedical discourse during accounts of often controversial psychiatric practices and treatment methods (Georgaca, 2013). Harper (1999), through a discourse analysis of talk from a psychiatrist's account of apparent medication failure, explored how professional justification for the practice of prescribing medication relied upon a multifactorial account. This account positioned biology 'at the core' providing a biological basis for the patients 'symptoms' to be modified with medication, whilst justifying medication failure with a shift to a biopsychosocial accounts, such as 'personality patterns' (pp.16). Additionally, studies have highlighted a central role for biomedical discourses in the justification of controversial treatments including Electroconvulsive Therapy (ECT) (Stevens & Harper, 2007; Johnstone & Frith, 2005). In a discourse analysis of the interviews with eight psychiatric professionals, including six psychiatrists, Stevens and Harper (2007) reported how participants justified ECT by constructing recipients as severely ill, and stressing the biological basis and chronicity of their 'symptoms'. These studies also demonstrated how participants positioned themselves as expert medical practitioners who rationally apply medical procedures whilst objectively assessing the risks and benefits (Georgaca, 2013).

The research presented demonstrates that, despite apparent acknowledgement of the importance of people's social situations and life experience in psychiatrists' aetiological formulations, the approaches taken to alleviate distress appear dominated by those with an exclusive focus upon individuals, based largely on the assumption of modifying internal pathology and are justified through biomedical accounts of peoples problems (Boyle, 2011; Harper, 1996, 1999).

## 1.13. Summary of Introduction

Thus far, it has been argued that the understandings of the categories 'psychosis' and 'schizophrenia' have evolved within a particular cultural and historical climate, and through the technology of psychiatric classification systems have been repeatedly refined based upon the assumption that distressed individuals are acted upon by impersonal forces, usually a biological dysfunction, and therefore rendering their experiences as not meaningful or intelligible (Jacobs & Cohen, 2010; Boyle, 2011). Furthermore that, empirical studies from both positivist and discourse analytic traditions highlight how the aetiological understandings of mental distress held by psychiatrists have implications for: psychiatric practices e.g., diagnosis and treatment; the identity of the people labelled as 'psychotic'; the meaning attributed to a person's distressing experiences; the lay understandings of such distress (Boyle, 2011; Johnstone, 2011). In the case of psychosis, it appears psychiatrists understandings are dominated by a biomedical aetiological model. However, as outlined, there exists a body of research that challenges key biomedical assumptions underpinning the category of psychoses. In recent years, aetiological constructions in the area of psychosis have become an increasingly contested area driven by support for alternative paradigms that acknowledge the role of relational, societal and contextual explanations regarding the cause of peoples' distress, particularly in relation to physical and sexual abuse (Harper, 1996; Johnstone, 2011). Despite this, there has been no research investigating how psychiatric professionals attempt to negotiate accounts the aetiology of a persons experiences of psychosis in the context of them having experienced 'trauma'.

## 1.14. Rationale for Current Study

A review of existing literature suggested a need to examine the contextualised narratives of psychiatrists whilst they explore the role of trauma in the distress and problems of people who receive diagnoses of psychosis. Current conceptualisations of 'psychosis' and 'schizophrenia' are informed by positivist research which focuses upon biomedical assumptions of individual pathology (Harper, 1996). Thus, these models do not provide space for contextual factors, such as experiences of sexual or physical abuse, for which a well established body of literature has strongly linked to

experiences of distress labelled as 'psychosis' or 'schizophrenia'. This has important clinical consequences given that research indicates a professional's construction of aetiology influences the well-being of patients at a number of levels. Therefore, given the influential position psychiatrists have in mental health services, it is important to understand how they negotiate available discourses to construct their aetiological understandings and practices when considering the distress labelled as 'psychosis' in the context of trauma. By increasing awareness of the discursive factors influencing psychiatrists accounts it will contribute to the process of understanding the effects of particular aetiological constructions such as, the meaning attributed to a person's distress, and access to appropriate interventions (Read, 2004; Boyle, 2002a).

Discourse analyses of professional accounts have demonstrated the variability of explanations drawn upon in order to account for, diagnostic decisions, a variety of treatment decisions, and apparent medication failure (Harper, 1996, 1999; Georgaca, 2013). Additionally these have various rhetorical effects, such as transforming an individual's distressing experiences to symptoms of a psychiatric disorder (Georgaca, 2013). However as discussed, variation, disagreement and contradiction are limited through the methodological processes of the cognitive research which has dominated this area (Willig, 2008; Harper, 2007). In contrast, a social constructionist perspective sees language as an active agent in this process rather than passive, and would allow exploration of how this contested area is linguistically negotiated by psychiatrists by using a methodology such as discourse analysis (Harper, 1996, 1999). Harper (1996) highlights that 'mental health is an arena of discursive encounters' (pp.28), and advocates discourse analysis as a particularly useful approach to understanding how contested issues are constructed by participants due to its focus upon the 'inherent variability of accounts' (Stevens & Harper, 2007, p. 7). For example, how a psychiatrist may use rhetorical resources which make a biomedical understanding of 'psychosis' seem more reasonable than one based upon adverse life experiences (Boyle, 2002a, 2011). Discourse analysis therefore provides a novel perspective on the accounts of professionals (Harper, 2007).

Thus, by exploring psychiatrists' constructions of the diagnoses of psychoses using

discourse analysis, the current study hopes to shed light on how psychiatrists negotiate available discursive repertoires to construct accounts of the link between trauma and psychosis, and account for their practices in response to the disclosure of childhood or adolescent experiences of trauma.

I will return to discussion of social constructionism and discourse analysis as an appropriate conceptual and methodological framework in the following chapter.

### 1.14.1. Aims of the study

Given the increasing attention upon alternative understandings of 'psychosis' in the context of increasing research as to a link with experiences of childhood and adolescent physical and sexual abuse; this research aimed to use a social constructionist perspective to bring an understanding of how the aetiological relationship between trauma and psychosis was linguistically mediated by psychiatrists. In doing so, the intention was to explore how a diagnosis of psychosis in the context of trauma was discursively produced and with what effects both for the psychiatrist and distressed person, as well as to shed light on the implications for practice (Harper, 1996, 1999).

The forthcoming analysis in chapter three will seek to answer the following questions:

***Research questions:***

1. How do psychiatrists talk to construct their understanding of the aetiology of psychosis given the evidence of a link between the early experiences of psychological trauma to later experience of psychosis?

2. Does a psychiatrist's construction of psychosis have implications for the diagnosis and treatment of a person with psychotic experiences who discloses history of experiencing psychological trauma?

## CHAPTER 2 - METHODOLOGY

### 2.1. Overview

The aim of this chapter is to identify the key theoretical assumptions that underlie the analysis used here and to outline how they are suited to the aims of the research. Alongside this, the epistemological framework is specified and how this informed the specific methods that were applied is considered.

As will be discussed in more detail throughout the chapter, a critical realist approach to Discourse Analysis (DA) is adopted in this study which is closely allied with social constructionism (Burr, 1995). A central concern of social constructionist approaches to qualitative research is how people use language. A central tenet of such an approach is that language, rather than simply functioning as a passive vehicle that reflects concepts or constructs, is seen as constitutive, and taken-for-granted notions – such as 'schizophrenia' and 'trauma' – are questioned (Burr, 1995). The implication is that it is assumed that people's accounts are constructed (although not intentionally) and perform certain functions. As such language does not simply define concepts such as 'psychosis' and 'schizophrenia', but is actively *creating* their meaning. The constitutive nature of language can be seen through inconsistency and variability in talk, and this sheds light on how speakers draw on different linguistic repertoires (Harper, 1995, 1996, 1999). For example, Edwards and Potter (1992) have described how there are a variety of rhetorical strategies drawn upon during the construction of factual accounts (e.g. empiricist accounting).

Although there will be some recognition of these rhetorical strategies in the analysis, research adopting a critical realist position goes beyond the text 'by setting what is said in a broader historical, cultural and social context (Harper, 2012, p. 93). By acknowledging the role of the extra-discursive, critical realist approaches enable the consideration of why people draw upon certain discourses (Sims-Schouten et al., 2007). As such, a Foucauldian approach to DA will be drawn upon and will principally focus upon a 'wider sense of effects and consequences', with the assumption that the accounts likely serve certain institutional interests (Harper, 1999, p. 9). A key example of this in the current research relates to how different aetiological models are drawn upon depending upon the version of 'psychosis' being

constructed, and how the invoked aetiological model may serve to legitimate the actions of a particular profession (Harper, 1999). Again, this does not imply intentionality. This layer of analysis will have a predominant focus upon the ways in which talk about the relationship between trauma and psychosis constructs a number of subject positions for people, including users of psychiatric services and professionals (psychiatrists), whilst discursively producing a range of objects (Harper, 1996, 1999). Thus, by exploring psychiatrists' constructions of the diagnoses of psychoses using discourse analysis, the current study hopes to shed light on how psychiatrists negotiate available discursive repertoires to construct accounts of the link between trauma and psychosis, and account for their practices in response to the disclosure of childhood or adolescent experiences of trauma.

### 2.2. Epistemology

This section explores the rationale for adopting a critical realist social constructionist position during this study. Epistemological positions can be conceptualised along a continuum between two poles, namely 'realism' and 'relativism' (Harper, 2012). Generally, realism asserts that an external world exists independently of our representation of it (Searle, 1995). Whereas relativism holds that reality, or an external world, is not directly accessible and therefore it is not possible to make comments about the nature of 'reality' (Harper, 2012; Cromby & Nightingale, 1999). Social constructionism is considered relativist in several ways:

> 'its scepticism about a direct relationship between accounts and reality, and its assumptions that we do not make direct contact with the world but, rather, our experience of it is mediated through culturally shared concepts - in other words, language shapes our experience of reality' (Harper, 2012, p. 91).

Social constructionism broadly describes approaches which are 'principally concerned with explicating the processes by which people come to describe, explain, or otherwise account for the world (including themselves) in which they live' (Gergen, 1985,p. 266). Social constructionist researchers focus on exploring the variety of ways of constructing social reality which are available within a particular cultural and historical context, the conditions within which these ways of constructing are often used, and reflect upon the implications of these for those who are 'positioned' and

'subjectified' by these social constructions (Willig, 2008; Brown et al., 2011). However, social constructionism has been criticised for not adequately considering significant elements of human life including, embodiment, materiality and power (Cromby & Nightingale, 1999).

The critical realist social constructionist epistemological position adopted in this study, combines constructionist and realist positions and holds that whilst 'meaning is made in interaction, non-discursive elements also impact on that meaning' (Sims-Schouten et al., 2007, p. 102). Therefore it is considered a non-relativist approach to social constructionism (Willig, 1999). Within a critical realist social constructionist approach, language is understood as constructing our social realities and world, though there is an acknowledgement that 'these constructions are theorized as being shaped by the possibilities and constraints inherent in the material world' (Willig, 2008; Sims-Schouten et al., 2007, p.102). As such language may not provide direct access to reality. Whilst emphasising the importance of discourse, critical realists do not regard it as the primary unit of analysis holding that there is more to the world than discourse and advocate an analytic focus that includes the non-discursive as well as the discursive. Such an approach allows the combination of constructionist and realist positions to propose that while meaning is made in interaction, non-discursive elements also influence that meaning (Sims-Schouten et al., 2007). For example, the present research goes beyond the language used by psychiatrists to describe how they integrate the link between experiences of trauma and people receiving a diagnosis of psychosis, into their 'expert' understanding of the aetiology of psychosis. This allows acknowledgment of potentially unrecognised factors that might be influencing such constructions e.g. embodied factors. The advantages of taking a critical realist position in this research are: it allows consideration of the effects and functions of psychiatrists drawing upon certain discourses; it can explore the impact of material practices on discursive practices; and finally, it supports an ethical stance given that the analyses allows the contextualization of psychiatrist's talk by positioning it within the materiality that they have to negotiate (Sims-Schouten et al., 2007). This is an epistemological position that most closely mirrors that of mine. For example, I believe in the reality of the body as a 'biological machine that provides the material preconditions for subjectivity, thought, emotion and language'

(Nightingale & Cromby, 1999, p.10). However, I also believe that the meaning attributed to bodies varies across historical, cultural and social context (Nightingale & Cromby, 1999; Harper, 2012).

There is several key criticism of this epistemological position which highlight a tension between relativist social constructionist and critical realist social constructionist positions (Willig, 2008). First, that the extra-discursive can be conceptualised as a discursive accomplishment (Sims-Schouten et al., 2007; Willig, 2008). Secondly, that researchers working within a critical realist framework have no systematic method of distinguishing between the discursive and the non-discursive, and are therefore open to the influence of the researcher's political inclinations (Sims-Schouten et al., 2007). These issues will be explored further in the discussion section (Chapter 4).

In adopting a critical realist social constructionist position in this research there will be an acknowledgement that the world is made up of social and material realities that play a role in structuring our actions, impose constraints on what we do or say, and therefore have implications on how we construct the world in particular contexts (Willig, 1999, 2008). These 'relatively enduring structures' cannot be directly accessed however, can be 'detected through their effects' (Willig, 1999, p. 45). This research will attempt to acknowledge 'extra-discursive' factors that, acting in conjunction with discursive practices, influence subjectivity (Willig, 1999; Fleetwood, 2005, p.222). In order to address the concerns that critical realist approaches have no systematic method for distinguishing between the discursive and non-discursive, this research will draw on the recommendation of Sims-Schouten *et al.,* (2007), who suggest an analytic focus on the following three extra-discursive factors; embodiment, institutions and materiality.

A review of the literature presented in the introduction to this study, oriented the researcher to the identification of possible extra-discursive factors that may influence psychiatrists constructions of the relationship between trauma and psychosis. As such, the analysis of psychiatrists talk regarding the relationship between trauma and psychosis, will be concerned with the influence of embodied factors (e.g. subjective experience of asking about child abuse), the way the material world

shapes and informs social constructions (e.g. employment or current clinical role), and the power of institutional practices (e.g. policies and procedures for the treatment of psychosis) and practices such as the speaker's use of dominant discourses (e.g. the medical model of psychosis aetiology) (Cromby & Nightingale, 1999).

### 2.3. Reflexivity

In constructionist research, it is important to remain aware of the researcher's contribution to the co-production of data and that they are not merely a neutral observer (Willig, 2008; Silverman, 1997). It is therefore, important to explore ways by which the researcher's involvement 'influences, acts upon and informs' this research (Nightingale & Cromby, 1999, p.228). Willig (2008) highlights that there needs to be consideration of both personal and epistemological reflexivity. Personal reflexivity considers how the researcher's values, beliefs, political aims and social identities have shaped this research. The recruitment, interview and analytic process have been influenced by the researcher's position as a clinical psychology trainee undertaking critical and qualitative research in a contested area as the construction of the aetiology of psychosis. This is particularly relevant when considering that the interviews are with psychiatric professionals whose training and practice is influenced greatly by 'naive realist' research which draws on positivist paradigms (Harper, 1996). At a personal level, the researcher is driven by a belief that the experiences of child and adolescent abuse and adversity survivors should be acknowledged and not pathologised. The researcher kept a research journal throughout this study to aid a process of reflexivity, this will be considered further in the discussion section.

### 2.4. Discourse Analysis

Discourse analysis can be seen as an umbrella term describing a variety of qualitative methods, with the chosen method being greatly dependent upon 'the epistemological framework being drawn upon' (Graham, 2005, p. 2). Common to all discursive approaches is that language is viewed as not simply describing psychological and social 'reality', but rather as constituting objects, events and experiences (Coyle, 2007). There is a growing body of research with a focus on

language use as social action (Harper, 1995). Language is viewed as constitutive and as something worthy of study in itself because of its effects (Harper, 1995, 1996, 1999). Harper (1995) suggests that such an approach to DA is useful when exploring phenomena such as psychiatric categories (psychosis) that are largely produced within language (e.g. in ward rounds, diagnostic interviews, case discussions etc.). Furthermore, it is said that 'mental health is an arena of discursive encounters', and therefore DA is a useful approach to understanding how contested issues are constructed by participants due to its focus upon the 'inherent variability of accounts' (Harper, 1996, p.28; Stevens & Harper, 2007, p. 7). Importantly, a discursive approach is able to acknowledge how accounts serve a number of 'personal, interpersonal, social, institutional and societal interests' (Harper, 1995, p. 350). Therefore, rather than seeing discursive constructions as manifestations of a speakers 'underlying cognitive states', they are analysed in the context of their occurrence (Edwards & Potter, 1992, p.2).

There are two main approaches to the study of discourse; discursive psychology (DP) which views language as a form of social action and is concerned with the 'micro level' of discursive practice and the effects of these in interpersonal contexts (e.g. rhetorical devices and there use in the action orientation of talk); and Foucauldian discourse analysis (FDA) which focuses more upon the 'macro level' of discursive resources within a culture and its implications for those who live within it (e.g. how accounts of objects, events or experiences are located within wider cultural or institutional contexts) (Harper, 1996, 1999; Willig, 2008).

Drawing upon the work of Harper (1999), there will be an acknowledgement of the rhetorical devices and strategies used by the speakers when talking about 'psychosis' and 'trauma', with a particular focus upon strategies used by the speaker to produce discursive objects as real (Harper, 1999; Edwards and Potter, 1992). However, the primary focus of the analysis will be the linking of the participants' talk with culturally available discourses and institutional power. Therefore, the analysis will be predominantly informed by a Foucauldian discursive analytic (FDA) principles which will be helpful in contextualising the use of language. FDA is interested in language beyond the immediate context of its use, focusing upon discourse in wider social processes of legitimation and power that can 'facilitate and limit, enable and

constrain what can be said, by whom, where and when' (Willig, 2003, p. 171). FDA's interest in language goes beyond the immediate context of its use by speaking subjects and, thus, asks questions about the relationship between 'discourse and how people think or feel (subjectivity), what they may do (practices) and the material conditions within which such experiences may take place' (Willig, 2008, p.113). FDA can be carried out on a wide range of texts including transcripts of interviews (Parker, 1999).

### 2.4.1. Developing a critical realist approach to analysis informed by Foucauldian principles

The method developed in this research was influenced by the suggestions made by Sims-Schouten, Riley and Willig (2007). They posit that a critical realist discourse analysis standpoint should be that the ways people understand themselves are structured by 'personal, psychological and social mechanisms', which offer a range of possible ways-of-being (Sims-Schouten et al., 2007, p.107). Influenced by this, the researcher selected a critical realist approach to FDA. This approach allows the consideration of material dimensions and thereby provides context as to why 'certain discourses is more or less easily enabled' (Sims-Schouten et al., 2007, p. 103). Further this approach not only allows the mapping of the ways 'participants use discourse to construct particular versions of reality', but also draws attention to how the materiality they have to negotiate influences their talk (Sims-Schouten et al., 2007, p. 103).

Accordingly, an analytic plan was developed with a primary focus upon the objects and practices by which the relationship between trauma and psychosis can be 'problematized' (Foucault, 1985). Therefore, the researcher attempted to identify the discursive objects constructed through the talk of psychiatrists when exploring their professional experience of working with people diagnosed as psychosis who have disclosed experiences of trauma. Additionally, the research considered how the psychiatrists positioning of trauma and psychosis become constituted through certain discursive and material practices designed to exercise power over the self (Rose, 1996). These practices have been defined as 'technologies of power and of the self',

including both the distal practices, such as professional knowledge, and proximal practices, such as diagnosis (Foucault, 1988).

### 2.5. Ethical Considerations

During the process of designing this research and formulating the research question I considered several political and ethical dimensions. To aid this process, several questions posed by Willig (2008) were held firmly in mind throughout, including; 'in whose interest is the research question, and how the answers to it may be used by individuals and organisations in society?' Importance was placed on such questions as this research may have implications for those taking part, as well as to clinical psychologists and people who may use psychiatric services. Furthermore, the researcher attempted to remain reflexive throughout this research as it is difficult to anticipate the ethical issues that might arise during the research process (Brinkmann & Kvale, 2008). Ethical approval for the research was granted by the ethics committee of the University of East London (appendix 2).

At each stage of the recruitment process attempts were made to ensure participants were fully informed and had opportunities to opt-out. These ensured participants were actively volunteering to take part. The research adopted an 'opt-in' method, which required participants to actively make themselves available by choosing to respond to an initial email. At several stages during the recruitment and interview process, participants were given the opportunity to withdraw from the research and it was ensured they were as fully informed as possible, the researcher ensured: a) participants had read and understood the information sheet and they were offered the opportunity to clarify any areas of uncertainty (appendix 3); b) written consent form signed following it being explained by the researcher (appendix 4); c) participant were given the opportunity to ask questions about the research; d) confidentiality of information about participants; e) participants were provided with the contact details of the researcher should they wish to gain further information at a later date. It is again acknowledged that the concept of informed consent is difficult in research that has an open-ended and exploratory nature, however, at the end of each interview the participants were offered the opportunity to request the omittance of sections of the interview.

Regarding the researcher's own positioning, the researcher introduced them self at the start of each interview as a trainee clinical psychologist based at the University of East London. Participants were encouraged at the start of the interview to speak freely and openly, and to express their own thoughts and experiences throughout the interview, this was further encouraged by the interviewer adopting a semi-structured interview style. Each interview began with the researcher beginning the interview with the statement that they were seeking the interviewee's expertise and experience of working with people who had received a diagnosis of psychosis.

### 2.6. Inclusion Criteria

The selection of participant was limited to mental health psychiatrists currently working or recently worked in the U.K National Health Service. Core psychiatry training requires specific clinical experience of working with individuals with a diagnostic label of a psychotic disorder, therefore, this research did not exclude any qualified or in training psychiatrists.

### 2.7. Recruitment

Participants were recruited using an opportunist sampling method. An email was circulated to fellow University of East London clinical psychology trainees requesting they forward the email to psychiatrists they were in contact with. The email contained the following information; a short paragraph describing the research, a participant information sheet, consent form, ethical approval reference and the researchers contact information, and email address which can be used to confirm participation or to request further details of the research from the researcher. The rationale for this method was that clinical psychology trainees will have been on several placements across the North Thames region of London and will have had professional contact with psychiatrists. Following an expression of interest from a psychiatrist they were invited to attend an interview at a time convenient for themselves.

### 2.8. Participants

Seven psychiatrists were recruited to participant in this study. This was considered to be a sufficient sample size given that the interviews were expected to last in region of 60 minutes. Miles and Huberman (1994) suggest small sample sizes are most

suitable for qualitative research as they allow in-depth study of people in their context. Morse (1994) suggested at least six participants were required for saturation of data content to be reached. Furthermore, Discourse analyses do not make claims of representativeness of samples (Coyle, 2007). By not limiting the sample to psychiatrists working primarily with people who had a diagnosis of psychosis, it was hoped that participants with a range of experience and material circumstances would be attracted. As previously mentioned, this was not consider a problem as all psychiatrists must undergo a core training placement working with people with a diagnosis of psychosis.

The sample was comprised of five women and two men, aged between 25-34 and 55-64 years old. The participants were at a range of stages in their careers, one at ST4, one at CT1, three fully qualified, two consultants psychiatrists, and one retired consultant psychiatrist (first year of retirement). The participants were currently employed in a range of clinical settings; one in an early intervention for psychosis team, one in a crisis resolution team, one in a child and adolescent community team, one in an older adult team, two in a community learning disabilities team, and one recently retired from an acute outpatients team. Five of the participants were currently working with people who had frequently received diagnoses of psychosis.

### 2.9. Data Collection

Data for the study was collected by the researcher through the medium of semi-structured interviews with the participants. Interviews were chosen as the data collection method because the study is interested in how professionals construct accounts of the relationship between trauma and psychosis, for example how they might provide justification for a particular aetiological model. It was considered that interviews would allow the inclusion of each participant's views, and would provide an opportunity to explore the individual psychiatrist's perspectives in detail using their own language (Frith & Gleeson, 2012). In addition, interviews do not require the sampling of data from a large number of people and therefore were considered more manageable for the scope of this research (Coyle, 2007).

Potter and Hepburn (2005) have drawn attention to several problematic features that are considered a necessary part of doing interviews. These problems include:

interactional features, such as its status as a conversation between two people; and the stake and interest that both participants have in the interview (Potter & Hepburn, 2005; Willig, 2008). It was therefore important to not assume the interviewee's words directly reflected their thoughts and feelings (Willig, 2008). Instead, the interviews were regarded as an arena where culturally available discourses and rhetorical strategies would be at work (Potter, 1996).

The interviews followed an agenda that was produced beforehand and were structured according to the studies questions and aims. The questions were methodically generated by basing them upon a review of existing literature and through discussion with the research supervisor (appendix 5). The agenda consisted of a small number of topic headings, around which the researcher formulated questions during the course of the interview based upon the responses from the participant. This allowed the incorporation of the interviewee's own terms and concepts into the questions. The intention of using this method was to make the questions more relevant to the interviewee as well as to maintain continuity and rapport throughout the interview. The topics were aimed at prompting participants' accounts of the context and experience of working with people diagnosed with psychosis who have experienced childhood or adolescent trauma. Specifically, the main topic areas that were discussed in each interview were: the aetiological models that the participants drew upon; and the diagnosis, treatment and prognosis of people who have been diagnosed with psychosis and who disclose childhood experiences of trauma.

The researcher aim was to encourage diverse accounts during the interviews. Therefore participants were encouraged to give voice to what otherwise might be assumed to be implicit assumptions and expectations. The interviewer attempted to keep questions as short as possible and allow the interviewee the space to give full answers, encouragement such as, "Could you tell me more" were used to facilitate richer responses to relevant areas (Kvale, 1996).

All participants chose to be interviewed at their place of employment. The interviews ranged in length between 32 minutes to 1 hour and 5 minutes, with the average interview lasting around 52 minutes. The latest potential finishing time of the

interview was negotiated at the beginning and was usually dictated by the participant's schedule.

### 2.10. Transcription

The researcher transcribed all interviews verbatim using simplified transcription criteria adapted from Potter and Wetherell (1987) (appendix 6). This style and level of transcription was deemed suitable given that this study was not predominantly focussed on the micro level features, instead the focus was upon the broader discursive constructions (Malson, 1998).

### 2.11. Process of Analysis

Having made notes in my reflective journal during the transcription stage (examples appendix 8), I identified a starting point for the analysis by articulating a question based upon the research aims:

"Under what circumstance are the relationships between trauma and psychosis rendered problematic and what official discourses and counter-discourses render these problems visible and intelligible?"

The process of analysis was informed by six analytic stages described by Willig (2008) and informed by Arribas-Allyon & Walkerdine (2008), and Harper (1999).

1. *Discursive constructions:* Highlight all the instances of reference to the discursive objects of 'psychosis' and 'trauma'. How are psychosis and trauma constructed through language, and what type of object is being constructed? What linguistic repertoires are evident when talking about 'psychosis' and 'trauma' including, rhetorical devices and strategies used by the speakers (Harper, 1999; Edwards and Potter, 1992).

2. *Discourses:* Location of the various constructions of psychosis and trauma within wider discourses. Under what circumstances and by whom are aspects of psychosis and trauma rendered problematic? According to what moral domains or judgements are these concerns allowed to circulate? What official discourses and counter discourses render these problems visible and intelligible?

3. *Action orientation*: What is gained or achieved from constructing psychosis and trauma a particular way at a particular point in the text? What technologies of power and of the self are evidenced in psychiatrists talk and how do they enable psychiatrists to make sense of interactions with people who have experienced childhood trauma and are diagnosed with psychosis?

4. *Subject positions*: A location for persons within a structure of rights and duties for those who use that repertoire (Davies and Harre, 1999. p.35). How does the subject position of a psychiatrist and their location within a structure of rights and duties, allow them to speak the truth about the link between trauma and psychosis. How does this subject position offer a perspective from which to view a version of reality, but also a moral location within spoken interaction with others?

5. *Practice:* By constructing particular versions of psychosis and trauma what possibilities for action are mapped out by them? What can be said and done from within these subject positions?

6. *Subjectivity:* At this stage there is an attempt to make links between the discursive constructs used of trauma and psychosis and their implications for subjective experience. How are psychiatrists formed via technologies of power and self, and how do they engage in practices of self regulation to transform themselves in order to attain a state that allows them to remain in a position of responsibility? (Foucault, 1988).

From the initial coding stage where the transcripts were read and reread, several major 'discursive sites' were identified which appeared to account for the groups of constructions identified (example of coding appendix 7). Providing these stages of analysis is attempt reduce ambiguity by being explicit about the process followed. Although by presenting these stages there is an attempt to orientate the reader to the process of analysis, I acknowledge the 'multiplicity of interpretations' available when interrogating the text, and it is stressed that this research presents a reading of the data and is not the only possible reading (Willig, 2008; Graham, 2005, p.5).

The next chapter will report, explore and discuss the outcome of the analysis.

## CHAPTER 3 - ANALYSIS

In this section there is an examination of some of the interview extracts. This examination is driven by the research questions outlined in the aims of this research. Initially, the analysis of the interview extracts is concerned with the aetiological models that are drawn upon by the psychiatrists to construct the relationship between trauma and psychosis. In the second section, the extracts are analysed with respect to the practices that are supported by the constructions that are drawn upon by the psychiatrists. Although these analysis sites are presented in separate sections they should not be considered as mutually exclusive, but instead as an interconnected network of discursive practices which work together to produce the concept of trauma and its relationship with psychosis (Morrison, 2003; Rose, 1979).

This analysis section focuses upon the analysis of the interviews in the context of wider cultural and professional culture, and concerns the aetiological models which are drawn upon by psychiatrists to consider the relationship between trauma and psychosis. Following this the analysis will consider the consequences of and possibilities opened up by these constructions e.g., treatments, and subject and object positions (Willig, 2001). Extracts from the participants' transcripts will be used to illustrate how constructions are made possible, the subject positions, and the social practices enabled by them (Arribas-Ayllon & Walkerdine, 2008).

It is not possible to comment on all of the features of each extract, therefore I have focused upon those most relevant to the research aims.

### 3.1. Discursive Constructions of 'Trauma' and 'Psychosis'

Although the main focus of this analysis will be upon the how psychiatrists construct the relationship between trauma and psychosis, this initial section will foreground this by exploring what the terms 'trauma' and 'psychosis' were used to describe in the interviews and to what effect. This section will be necessarily brief, given it is not the main aim of this analysis, and is intended only to draw attention to the variability of the constructions and the some possible effects of these.

### 3.1.1. Definitional constructions of 'trauma'

This section is intended to orientate the reader to the use of the term 'trauma' within the interviews and briefly point to a few possible effects of its use.

#### *3.1.1.1. Trauma as an objective entity as operationally defined by the ICD 10 or DSM*

**Extract 1:**

> Dr F: you look at ICD 10 and DSM /Res: mm/ you know it's [trauma] linked to, having as I say, being caught up in an earthquake, tsunami, you know major stuff (997-999).

This extract is an example of how 'trauma' was constructed through reference to the psychiatric classification systems 'ICD 10 and DSM' (line 997) (APA, 1994; WHO, 2010). Features of this repertoire were seen in several of the psychiatrists accounts (Dr F line 997; Dr A line 231; Dr B line 204). An effect of locating 'trauma' within a professional discourse of psychiatric classification is that adverse experiences such as, 'being caught up in an earthquake', are incorporated into a pathology framework which considers them as separate from the human world and are evaluated without regard to circumstances (Jacobs and Cohen, 2010). Furthermore, by drawing upon psychiatric classification definitions of trauma, notions of objectivity and individualism are privileged (Patel, 2011). The effect of this is to construct a 'traumatized individual' who becomes the focus of practices concerned with diminishing psychological distress. Such a position directs focus away practices that might address causes, and consequently neglects exploration of the contextual factors that may influence distress such as poverty, access to education and racism (Johnstone, 2011; Patel, 2011). This perhaps represent a societal technology of power that limits exploration of the conditions that make possible the physical, sexual and emotional abuse, as well as many damaging environments people are required to exist within (Foucault, 1988).

*3.1.1.2. Trauma as severe stress*

**Extract 2:**

Dr A: trauma is one of the umm, like it's one of the (.) It's, it's a huge stressor, compared to a lot of other stress I would consider trauma to be much higher degree of stress (96-98).

As in this extract, several of the psychiatrists construct trauma as synonymous with "severe stress" or as a 'huge stressor', this was a theme pervasive throughout the accounts (e.g. Dr G line 165; Dr A, line 96). This draws upon a positivist epistemological discourse which constructs trauma as having a 'dose effect', with exposure to particular event having an increasing universally objectifiable risk of experiencing a distressing reaction (Mollica, 2000). Furthermore, the equating of traumatic experiences with stress was associated with conceptualisations of distress that draw upon a vulnerability-stress discourse, whereby 'stress' is positioned as a 'trigger'. An effect of doing so is to position adverse life experience as the equivalent of a trigger for an underlying individual pathology or illness, thereby simultaneously stripping its meaning for that person (Johnstone, 2011). Furthermore, the technical terms 'trauma' and 'stress' allow the subject to avoid having to describe the events in detail, as well as having to engage with any personal meaning they may have for the survivor (lines 96, 98) (Boyle, 2011).

*3.1.1.3. Trauma as term to convey complex damaging experiences*

**Extract 3:**

Dr G: trauma usually suggests something, severe stress /Res: uhuh/ in a person's life, um, this kind of trauma could be anything like sexual abuse, physical abuse, emotional abuse (165 -168).

Here, 'sexual' and 'physical' and 'emotional abuse' are used as examples of both 'trauma' and 'stress'. This was common to all of the psychiatrists interviewed (e.g. Dr F, 1000 ;Dr B, 209, 378; Dr D, 357; Dr G, 168). This perhaps represents how the construct of 'trauma' and its synonyms such as 'stress' have become embedded in psychiatric language to convey the complexity of harmful interpersonal and relational

patterns (Boyle, 2006). There are several effects of this construction; whilst acknowledging severe psychosocial factors it simultaneously fails to acknowledge a wide range of everyday but possibly damaging experiences such as racism, or family communication problems (line 165) (Johnstone, 2011; Boyle, 2006). Secondly, it allows the psychiatrist to summarize people's experiences whilst avoiding detailed description of the often shocking detail of people's experiences (Boyle, 2006).

### 3.1.2. Definitional Constructions of Psychosis

Again this section is intended to orientate the reader to the use of the term 'psychosis' within the interviews and briefly point to a few possible effects of its use. A more detailed analysis occurs throughout the later analysis sections, where some of the issues raised will be explored further. This section is closely based on the observations of Mary Boyle (2006).

#### *3.1.2.1. Psychosis as synonymous with schizophrenia*

**Extract 4:**

> Dr A: So there's this typical psychosis that represents, that, that starts later in life and a very schizophrenia like feeling, that disconnection of affect, true hallucinations, real paranoia, responding to stimuli umm, and whatever the causes, if you forget the aetiology, it looks like true psychosis (184-189).

This extract demonstrates how, what is called here 'typical psychosis' is seen as synonymous with the diagnostic category 'schizophrenia' (Boyle, 2006). The effect of this construction is to implicitly transfer to the label 'psychosis' the taken-for-granted biomedical aetiological assumptions of schizophrenia (Boyle, 2002a).

*3.1.2.2. Psychosis as a generic noun*

**Extract 5:**

Dr D: (.) Well, I mean I would adhere to the convention of erm, criteria for diagnosing erm, psychosis er, in terms of the usual need for delusions, hallucinations, possibly thought disorder er, of a particular duration and of which will often be distressing, impair function, possibly you know risk to self and others associated, and some combinations of those aspects, but particularly central features of abnormal experiences, abnormal beliefs, abnormalities of thought (7-11).

This extract demonstrates how psychosis was used in the interviews as a generic term, within which exists a diagnosis 'schizophrenia'. Commonly there was a reliance upon the biomedical language of symptoms such as, 'thought disorder' and 'hallucinations' and 'diagnosis' (lines 8-9) (Harper, 1996). The effect of using psychosis this way is that the traditional biomedical assumptions of schizophrenia remain unchallenged and potentially assimilated (Boyle, 2006).

*3.1.2.3. Psychosis to avoid the use of 'schizophrenia'*

**Extract 6:**

Res: if you're kind of explaining psychosis to someone, how would you do that?

Dr G:That's a very interesting point isn't, especially we have people with first episode psychosis /Res: mmm/ we don't want to scare them off_/res: sure, yeah/_ erm with terms like schizophrenia /Res: mmm/ which does not mean much really, erm there's been quite a lot of debate about whether this should be changed (19-31).

In this extract the term 'psychosis' allows the avoidance of the negative perceptions and stigma that surround the term 'schizophrenia'. This perhaps represents how 'psychosis' is used as a more user-friendly and less stigmatizing diagnosis in mental health services (Johnstone, 2011). Here psychosis is perceived by the speaker as a less threatening descriptor of the associated distressing experiences, whilst the

possibility of a future diagnosis of schizophrenia remains. Furthermore, there is an assumption that psychosis has more meaning to the distressed person, whilst the language and assumptions traditionally associated with schizophrenia remain unchallenged and possible transferred to that of psychosis.

*3.1.2.4. Psychosis as an independent concept*

> **Extract 7:**
>
> Dr F: Psychosis is kind of the disturbance of a person's relationship with the real world. So it's an abnormal_ the abnormalities include abnormalities of thinking, of mood, behaviour (43-45).

In this extract, the term 'psychosis' is used without reference to 'schizophrenia'. The speaker constructs 'psychosis' as a generic concept that accounts for a change or 'disturbance' in the way a person relates to an apparently rationally objectifiable 'real world' (line 43) (Georgaca, 2013). Although the effect of such a construct is space for conceptualizations that are not limited by the assumptions of schizophrenia, there is a focus upon individual psychological and behavioural consequences of psychosis, such a focus does not offer space to consider causal factors such as trauma (Boyle, 2006).

## 3.2. Constructions of the Relationship Between Trauma and Psychosis

The previous section has offered a brief analysis of some of the ways in which 'trauma' and 'psychosis' were conceptualised in the interviews, and how the particular version being drawn upon offers differing understandings of the phenomena being described.

In this section there is an examination of how the psychiatrists variably construct the experiences of people diagnosed with psychosis in the context of trauma, by drawing upon three theoretical approaches namely; biological (or biomedical), psychological and social. These theoretical orientations are aspects of what is known as a 'biopsychosocial' model of the causation of distress (Engle, 1980). Presented in this section are examples of how the psychiatrists spoke about individual aspects of such a model  when considering the aetiology of psychosis in the context of experiencing

trauma in a person's life e.g., biomedical aspects. This section also includes an example of how these aspects were constructed in relation to each other to provide an integrated and multifactorial aetiological narrative of the relationship between trauma and psychosis.

The role of trauma is spoken about differently depending upon which aspect of the biopsychosocial model is being drawn upon. There has been an attempt to show each of these discourses in action individually, though there is inevitably some overlap in their deployment.

### 3.2.1. Trauma as a trigger to a biogenetic vulnerability

In constructing the aetiology of psychosis in the context of traumatic experiences, various accounts were deployed that served to produce trauma as a 'trigger' to a biogenetic vulnerability to developing 'psychosis'. These constructions enabled a variety of practices in terms of how the psychiatrist might respond to a person who is diagnosed with psychosis.

**Extract 8:**

Res: you describe kind of a 'true psychosis' and erm kind of more say for instance a psychosis that's maybe more around PTSD, do you, do you consider, do you have different aetiological models for each of those, or and do you think that maybe trauma is maybe associated with one more than the other? (250-255).

Dr B: My understanding of it is that erm, (.) if the person has certain er genetical background with the exposure to certain degree of trauma this person will develop a certain illness, so basically if I'm genetically programmed to develop schizophrenia in the case of exposure to certain degree of distress then I will become schizophrenic, if I'm programmed genetically not to develop psychosis, true psychosis, schizophrenia let's talk about schizophrenia let's talk about schizophrenia yea, it,it,it's, if I do

> not carry genes which predispose me to dopamine dysfunction in my brain, severe dopamine dysfunction severe dopamine excess in my mesolimbic system then, I will be, even when exposed to severe stress during my childhood I will probably be less likely to develop schizophrenia but I will be more likely to develop er er trauma related emotional er er instability, which will manifest in all sorts of behavioural outcomes of er behavioural symptoms of, of er borderline PD (256-270).

In this extract, the psychiatrist is responding to a question regarding the aetiological models drawn upon when conceptualising psychosis and PTSD. The speaker begins the account by offering the following qualification, 'My understanding of it is that' (line 256). This is a useful rhetorical strategy when exploring contested areas, in this case the relationship between trauma and psychosis. By doing so, the psychiatrist is able to manage challenges to their formulation by responding that it was only their understanding that was being offered (Edwards & Potter, 1992). The psychiatrist goes on to develop an 'empiricist account' which draws upon scientific language including 'genetical background', 'genes', 'dopamine dysfunction', 'mesolimbic system', 'symptoms' (lines 257, 263, 265 & 270), to construct a biomedical account of how trauma is linked to psychosis (Edwards & Potter 1992). The use of this highly specialised objective language has several effects. First, by giving agency to physical events, such as brain chemistry and genetic markers, which are considered to be objectively indicative of a diagnosis of schizophrenia, an impression is fostered that 'schizophrenia' is an organic disease (line 263). Second, such language is part of a technical rational repertoire, limiting or rendering inaccessible meaning to non-specialists (Kirk & Kutchins, 1992; Boyle, 2002a). It has been suggested that such language can contribute to an impression of reasonableness around this particular version by presenting what appear to be facts as if they have been discovered and verified (Coyle, 2007). Furthermore, the reference to becoming 'schizophrenic' (line 261) gives the impression of the attributes, and the role of trauma in this area, as applying to all those who fall into the 'schizophrenic' category, therefore allowing a generalisation to, or the homogenisation of, all people who have received such a diagnosis (Boyle, 2002a, p.214).

In addition, here Dr B draws on a metaphor of programming, 'so basically if I'm genetically programmed to develop schizophrenia in the case of exposure to certain degree of distress'(line 259). Thereby a sense of predetermined biogenetic function or vulnerability is reinforced, a position consistent with a stress-vulnerability discourse whereby trauma is constructed as a trigger to a primary cause of distress that lies in the biology of the individual. Therefore, although trauma is acknowledged, agency is primarily located in the predetermined biology of the individual - namely their genetics - whilst the patient is seen as passive. Within such an account the assignment of agency to the individual's internal biology has the effect removing agency from other potentially influential actors such as, survivors, family members, health services etc., and positions agency with internal biology of the individual (Harper, 1996).

Such a construction of the role of trauma can be found in other accounts in the transcripts for example;

> 'I wouldn't think of a trauma as a cause of a psychotic illness /Res: right yeah/ I would think of it as a trigger' (Dr E, 722-723).

Again, in this extract, trauma is explicitly referred to as a 'trigger' that is alone insufficient to cause 'psychotic illness' (line 723). Therefore, by constructing trauma as analogous to a trigger, psychotic illness is positioned as an object that exists over and above a natural and understandable reaction to a trauma, and is a disease process which emerges or is made worse by the trauma. Both extracts construct the presence of 'trigger' or 'exposure to certain degree of distress' as not sufficient in themselves to produce serious emotional distress (Boyle, 2011). By implication psychosis is constructed as something inevitable and beyond the control of the individual or society. Furthermore, experiences that may constitute trauma are therefore made meaningful, without having to explore the social or cultural context in which they occur (Patel, 2011).

Through repeated reference to a biomedical discourse of diagnoses by the use of the terms 'schizophrenia' and 'borderline P.D' (lines 259 & 270), there is an assumption of a disorder that is located within the individual, and therefore indicative of a biological cause (Harper, 1996). An individual, as opposed to social, nature of

'schizophrenia' is further emphasised through reference to 'genetical background', 'illness', and 'genetically programmed' (lines 257-259), which contribute to an impression of a pathological individual whose actions, thoughts and feelings are the consequence of internal properties. Furthermore this construction of a person's problems or distress as originating beneath the skin legitimates practices which target beneath the skin solutions, such as chemical interventions (Cromby & Nightingale, 2001). It also leads to what might otherwise be viewed as understandable reactions to life's challenges to being de-contextualised and instead transformed into internal individual pathology, with an accompanying label of 'psychosis' (Bracken & Thomas, 1995).

A further effect of the individual internalised construction dominant in this extract can be noted in the comment, 'which will manifest in all sorts of behavioural outcomes of er behavioural symptoms of' (line 269). Here little attention is paid to the content of a particular phenomenon or experience. Instead a diagnostic classification framework transforms behaviour into symptoms, classifiable as either present of absent (Barret, 1988; Harper, 1996). This medical imperative seeks to abstract generalities and commonalities, with psychiatric knowledge de-contextualising patients' experiences, by assuming that their meaning and function are not particularly relevant (Harper, 1996). Boyle (2002a) proposes that the pre-occupation with form over content is driven by the assumption that content is meaningless when compared to clinicians', rather than patients', belief systems.

### 3.2.2. Trauma as leading to an acquired vulnerability to develop psychosis

In constructing the aetiology of psychosis in the context of traumatic experiences, a variation of a stress-vulnerability account was deployed which constructed early life experiences of trauma as leading to an acquired vulnerability to future psychosis, drawing heavily upon theoretical ideas from psychological theory.

> **Extract 9:**
>
> Res: how did you kind of fit the ideas that you receive in family therapy [training] and kind of theoretical ideas around why people might become distressed with the, with your psychiatric views, or the kind of I guess more medical model ideas of distress as well, particularly in er_in the case of psychosis? (347-351).
>
> Dr D: you can only imagine that lots of things that should of happened for that person, brain wise, hasn't happened /Res: Sure/ you know, the kinds of connections the kinds of building up of the wiring if you like hasn't happened /Res: mmm/ and therefore they are, they're predisposed to (.) these kinds of distorting, distortions of perception or of belief that we call psychosis, or language disruption we call thought disorder. And on top of that the sort of suffering going with it you know, and also perhaps the lack of confidence in managing their lives, they haven't learnt or built up those confidences, and kind of coping mechanisms, problem solving er, mechanisms that would normally happen for most people who were brought up with what you might call adequate care and protection from err excessive traumatic experience /Res: mmm/ (403 - 420).

Here, whilst responding to a question regarding integrating theory learnt in family therapy training into a medical model of distress, the psychiatrist constructs a narrative of a link between adverse life experiences - in this case ' sexual abuse, physical abuse, emotional abuse' (mentioned earlier in the exchange, line 356) - and experiences labelled as 'psychosis', drawing upon a vulnerability-stress hypothesis discourse (Zubin & Spring, 1977). The speaker constructs a vulnerability, or 'predisposition', as an acquired neurological deficit saying, 'building up of the wiring if

you like hasn't happened' in the persons brain (lines 405-406), and links this with childhood experiences of abuse (line 356). In contrast to the biogenetic vulnerability constructed by Dr B (section 3. 2.1), here the vulnerability is constructed as environmentally acquired, and as leaving the individual at risk or 'predisposed' to developing 'psychosis' (lines 407-408). In doing so, the psychiatrist acknowledges the potentially damaging effects of adverse environments (Boyle, 2011). However simultaneously, there are several features of this extract which have the effect of decontextualising and transforming the person's more or less understandable reactions to life challenges into internal individual pathology (Rapley et al., 2011). First, through the use of structural metaphors such as 'building' and 'wiring', Dr D coveys a permanence and irreversibility of the neurological deficit, referred to as 'the things that should have happened for that person, brain wise' (line 404). The use of these metaphors offers the possibility of knowledge of an unseen realm below the surface that cannot be verified, but only made visible through observation of apparent surface manifestations, or signs, and which require verification through the knowledge and skills of psychiatric 'experts' (i.e. 'thought disorder') (Harper, 1996, 1999). Additionally, this is combined with the temporal positioning of negative experiences and the neurological ('brain' (line 404)) effects in the past, which creates a sense of remoteness and irreversibility (Boyle, 2011). It has been suggested that such a positioning is commonly used as a rhetorical device to justify the lack of attention paid to such experiences in psychiatric services, through a 'damage is done' discourse (Read et al., 2004; Boyle, 2011).

Second, a cognitive behavioural discourse is drawn upon, linking the experience of 'care' and 'protection' (lines 414-415), or the lack of in this case, as influencing intrapsychic variables or psychological structures such as, 'coping mechanisms' or 'confidence' (line 412). By doing so, a discourse of an individual victim is privileged over a discourse of social, with the effect of positioning trauma as disrupting the individual's life by influencing purely internal phenomena (Kleber et al., 1995; Beck, 1996; Sampson, 1981; Harper, 1996). This discourse promotes solutions that are focused upon the individual as opposed to those that might focus upon systems or context-specific factors that may affect distress, with this being reinforced by the remoteness of the events leading to the 'predisposition' (Cromby & Nightingale,

2001; Harper, 1999). Furthermore, the influence of traumatic experiences are positioned as 'predisposing' to, and the deficits in the functioning of internal psychological phenomena are positioned as 'in addition to', bizarre experiences such as, 'distortions of perception' associated with 'psychosis', by saying, 'on top of' (line 409). This formulation maintains a separation of mental phenomenon associated with psychosis from background contexts of the person, thus giving a sense of a person's social context as operating in isolation (Thomas & Bracken, 2004). By maintaining this separation the 'psychosis' and 'thought disorder' are positioned as individual pathology that requires additional explanation, over and above these experiences being the effect of abuse (Johnstone, 2007).

In this extract, the focus on diagnosis and a discourse of internalised pathology, neglects how a trauma discourse regulates survivors subjectivities by placing an emphasis upon vulnerability as a predisposition to a psychiatric diagnosis or 'lack of confidence in managing their lives' (lines 410-411), rather than 'resilience, survival and agency' (Patel, 2011). This perhaps represents the difficulty faced by mental health professionals in acknowledging both the individual and society. Harper (1996) suggests that privileging the individual itself is not sufficient given that the individual only exists 'against a background of society'. However a solely social and interactional account of madness can 'appear too abstract to theorize subjectivity', and sheds light on the who is doing the abusing and the social and cultural systems which facilitate it which can feel extremely overwhelming to professionals (Harper 1996, p.10; Smail, 2001)

### 3.2.3. Social context as a stressor

In the accounts there were various constructions that drew upon sociological theoretical ideas when talking about the relationship between trauma and psychotic experiences. This extract provides an example in which the psychiatrist is referring to more 'mundane' adverse life experience, such as arguments with family member, as opposed to the more typically referred to experiences of physical or sexual abuse. Additionally, as demonstrated in the section *3.1.1.2*, trauma is seen as synonymous with stress.

> **Extract 10**:
>
> Res: are there particular, are there particular models that you use or that you find most helpful when thinking about that [psychosis]? (92-94).
>
> Dr G: then we have issues of just stress factors, which clearly we see in our patients, when there's social stress, housing, benefits, whatever, they have a relapse /Res: uhuh/ and whether what you do with that, whether you resolve all the social issues immediately or whether you treat them [the patient] with medication and then deal with the, it's a different matter, but but stress is an important factor (res: uhuh), then you are looking at, these are immediate stress we are talking about just before the onset of the illness [psychosis] and that leads on to, you know it may be um, some arguments with a family member, but it has roots /Res: uhuh/ from the past (109-122).

In this extract, whilst responding to a question regarding aetiological models, the psychiatrist uses terms from both sociological and biological theoretical frameworks to explore how current 'stress factors' which may be influenced by 'past' experiences can be linked with a person receiving a diagnostic label of 'psychosis' (lines 109, 122). Sociological influences upon distress appear to be positioned as 'stress factors', with stress factors being contextual influences that are either distal such as, 'housing' or 'benefits' (lines 112, 113), or proximal such as, 'arguments with a family member' (line 121) (Smail, 2001). Simultaneously, biomedical language is used such as, 'relapse' or 'illness', which has the effect of positioning 'stress factors', and

therefore the person's social context, as influencing an underlying biological mechanism (lines 114, 120, 112). In addition, the psychiatrist separates 'stress' from 'illness' by saying 'just before the onset of the illness' (line 120), in doing so, it is implied that the 'illness' is caused by other things, rather than the stress being a sufficient explanation for the persons distress (Boyle, 2011).

Throughout the patient is constructed as a passive agent in several ways. First, social 'stress' is constructed as an external object, such as 'housing' or 'benefits', with agency to resolve such issues as external to the patient and with the 'expert', indicated by saying, 'whether you [professional] resolve all the social issues' (lines 115-116). Simultaneously, although the influence social context is acknowledged, its effects are decontextualised by explicitly locating it them within the individual saying, 'which clearly we see in our patients' (lines 112-113) (Rapley et al., 2011). In addition, there is a subtle biologisation of the patients themselves through the use of medical terms such as 'relapse' and 'illness' (lines 114, 120). These traditional medical terms take-for-granted biology as causal, and therefore that the patient is constructed as helpless victim of pathology that may return at any moment, and are therefore not responsible for their own distress (Harper, 1996, 1999). Through expressions such as 'what you do with that' or 'whether you treat them' (lines 115-116), professionals are constructed as making the decisions and possessing agency and the expert knowledge to treat the individual. However, interestingly the agency that a distressed person has in decisions around treatment or influencing housing matters, are not explored. It is possible that this represents the difficulty in integrating the individual/social opposition into aetiological models of psychosis which simultaneously construct the cause of 'psychosis' as biological and patients as passive, whilst suggesting there are ways distressed people can alter their social context to reduce relapse (Harper, 1996, 1999; Johnstone, 1993). Furthermore, the focus on effects ('relapse', line 114) of life experiences, directs the attention of professionals, and therefore interventions, on the 'illness' and away from the how and why people are subjected to the distress and suffering of abuse or assault, such as sexual and physical violence, poverty and racism (Patel, 2011).

### 3.2.4. Multi-factorial talk and the construction of the role of trauma in psychosis

The previous extracts in this section have shown how discourses derived from biological, psychological and sociological narratives were variably drawn upon in the interviews whilst constructing the aetiology of psychosis in the context of a possible link with trauma. The following section presents an analysis of an extract in which biomedical, psychological and sociological theories are integrated in an attempt to construct a 'biopsychosocial' narrative of psychosis aetiology in the context of trauma. It demonstrates the difficulty faced by professionals in accommodating sometimes conflicting accounts of distress.

Biopsychosocial or multi-factorial constructions have been shown to be commonly drawn upon in psychiatric services (Read et al., 2004). Such multi-factorial accounts of patient's problems have been illustrated in analysis of GP's accounts of their patient's difficulties and in psychiatrist's accounts of 'paranoia' (Gabe & Lipshitz-Phillips, 1984; Harper, 1999).

**Extract 11:**

Res: if someone had already received a diagnosis /Dr E: yes/ of say for, of a a psychotic /Dr E: yes/, on the schizophrenia, a psychosis or a schizophrenia /Dr E: so, yeah/ category, erm and they began to talk about, erm, a specific trauma that they had experienced /Dr E: yes/ in their life, would that influence how you would, first of all your diagnosis of them? And then maybe second of all how you approach that person, with treatment, etcetera? (344-352).

Dr E: I think, I think there isn't the time in the system that we work in. Not so much in our team, but in gen, mainstream psychiatry /Res: uhuh/ there is, isn't the time, the resources etcetera to, which is very sad for me to say, to, to explore that and to undo the problems and /Res: yeah/ so therefore it's a repeating pattern that just gets reinforced and reinforced and then people /Res: uhuh/ are in the system for twenty years and then you can't do anything about it /Res: mmm/, they are just institutionalised

> (.). The first bit was the diagnosis wasn't it? /Res: mmm/, I suppose this is where the medical model comes in again, erm I suppose the way I am trained to think about things is erm, actually it would be that that person had some genetic predisposition to developing a psychotic illness and the environment in some way perpet-precipitated that first episode /Res: right/ and that's probably how I would formulate it /Res: okay/, rather than it being another diagnosis so much. This is where it's helpful to understand symptoms actually /Res: uhuh/ erm because I think if somebody has sort of a negative erm view of the world, negative cognitions about the world and they've been abused in their early life and their psychosis is also erm persecutory erm, it's kind of more understandable isn't it? If somebody feels persecuted and is having a psychotic breakdown, if they've been abused or there has been a lot of expressed emotion in the home in early life and there's been very lots of criticism because, you know, Mum and Dad have, or just Mum or just Dad have been overly critical, actually their psychosis can be better understood, can't it? In all, well I think I think it could be understood /Res: uhuh/. Erm, and I suppose that it's a shame actually that we don't spend the time thinking about the context in which those symptoms arise and we label them with a psychosis and not really fully understand the context in which they've experienced that, those symptoms (409-443).

Here Dr E is responding to a question regarding the influence of the disclosure of trauma upon diagnosis and treatment. This account is extremely complex in its acknowledgement of trauma, in this case abuse in early life, and its relationship with psychotic experiences. Throughout the narrative there are several qualifications offered, including 'I suppose' (lines 419, 420, 439), 'probably' (line 420), 'I think' (lines 409, 427), and 'kind of' (line 431). The effect of these qualifications is the introduction of ambiguity and tentativeness (Edwards & Potter, 1992). Harper (1999) describes how such qualifications within professional accounts can act as a 'useful defence', as only tentative hypotheses were being offered to describe the influence of trauma in the aetiology of a person distress diagnosed with 'psychosis'. In addition, it allows the move to another tentative hypothesis in the event of being challenged.

The account given by Dr E draws upon a wide range of theoretical frameworks: sociological (e.g. 'environment' line 423), biological psychiatry (e.g. 'psychotic illness' line 422), cognitive (e.g. 'negative cognitions' line 429), attachment (e.g. 'expressed emotion' line 434), contextual or systemic (e.g. 'been abused' line 430) and behavioural (e.g. 'overly critical' line 437). In doing so, if one aspect were to be challenged, for example the evidence for a link between early life experience of abuse and a negative or persecutory view of the world, then the other candidates could be employed to explain the role of trauma in the aetiology of psychosis. Furthermore, the acknowledgement of multiple interacting frameworks gives the appearance of open-mindedness to - and an integration of - the various theories, thus constructing the speaker as a thoughtful and liberal professional. However, at the same time, by presenting them in a hierarchical fashion, with biology being placed as at the core, namely 'genetic predisposition' (line 421), the other factors - such as, abuse or attachment - are positioned as having an effect upon how, as opposed to interacting with, the assumed biological dysfunction manifests itself through symptoms (Harper, 1999). By drawing upon a biopsychosocial or multi-factorial narrative, Dr E's account utilises rhetoric of balance and a liberal assumptions that all aspects have some utility, whilst allowing current contested practices such as diagnosis, to be maintained through relativizing challenges (Billig, 1987; Boyle, 2011).

Initially Dr E positions themselves at a professional and institutional level as being required or obligated to work within a particular theoretical framework, namely the 'medical model', of understanding aetiology and the associated language in relation to 'psychotic illness' (line 419). Here it appears that an empiricist repertoire provides a framework to talk about 'psychopathology' and diagnosis (e.g. 'psychotic illness' and 'psychosis' lines 422 & 430), in a way that stresses an objective and impersonal approach, thus maintaining the scientific legitimacy Dr E's comments (Harper, 1994; Craven & Coyle, 2007; Georgaca, 2013). Simultaneously, Dr E redirects the diagnostic account to one where personal (e.g. 'it’s kind of more understandable isn’t it? If somebody feels persecuted and is having a psychotic breakdown', lines 431-433) and contextual factors (e.g. abuse, lines 430 & 433) are drawn upon to

understand a person's 'symptoms' (line 441), as such creating an account of a 'diagnosis' that is better 'understood' in relation to the persons context (line 438). This example of a 'contingent account' constructs the diagnosis of psychosis as influenced by a number of subjective factors, and recognises the professionals own investment and orientation to diagnosis (Harper, 1995). In drawing upon this repertoire, the psychiatrist appears to be acknowledging their subjectivity and personal agency in the diagnostic process as enhancing the process saying 'actually their psychosis could be better understood' (lines 437-438) (Harper, 1995). Thus, the use here of a contingent discourse could be viewed as serving to resist and undermine the taken-for-granted objectivity and impersonal nature of the 'psychiatric professional', a view which is perpetuated through an empiricist discourse (Harper, 1995; Craven & Coyle, 2007).

Interestingly, this contingent account is accompanied by an expression of regret at the lack of focus upon the adverse life experiences that may link to a person's distress when Dr E states, 'I suppose that it’s a shame actually that we don’t spend the time thinking about the context' (lines 439-441). This perhaps represents a dilemma faced by Dr E of acknowledging life experiences as contributing to a diagnosis within a mental health context where an empiricist discourse and the apparatus of diagnosis is institutionally dominant (Coyle, 2007). However by doing so, the speaker appears to be downplaying the authority of their expert position and agency, whilst in effect distancing her from such decisions. Again, it is possible this ambivalence represents the difficulty in integrating the assumptions of oppositional individual/social discourses into aetiological formulations of psychosis in the context of traumatic life experiences. On one hand Dr E's description is a biomedical account, whereby the patient is constructed as a passive sufferer of a (presumed) biochemical imbalance, and where a diagnostic categorisation is utilised as a basis for informing medical intervention. On the other hand, Dr E attempts to integrate a social account, which constructs the patient as an active agent with beliefs derived through experience, and thereby locates their problems in the context of personal and social circumstances. Correspondingly, such an account is linked to a supportively-orientated intervention focused upon their social context (Georgaca, 2013).

### 3.3. Strategies to Support a Biological Model of Psychosis Aetiology in the Context of the Challenge of Trauma

The previous sections have an analysis of some of the ways in which the language and representation of the relationship between 'trauma' and 'psychosis' may operate in constructing particular versions as reasonable and plausible (Boyle, 2002a; Harper, 1996).

Several authors have suggested that a threat is posed to psychiatry by evidence that both the form and content of emotional distress and 'disordered' behaviour - including experiences of trauma - are systematically, meaningfully and inseparably related to social context and life experience (Boyle, 2011, pg 35; Johnstone, 2011; Harper, 1999). Arguably, such threat is often managed through the deployment of common discursive resources which support a biomedical aetiological model of psychosis (Boyle, 2002b, 2011). This section will examine some of the specific rhetorical strategies used during the interviews in response to the possible challenge that is posed to the disease/illness model of psychosis by the role of trauma.

#### 3.3.1. The equivalence of psychosis and psychiatric illness: the use of the medical metaphor.

In the accounts, equating the equivalence of the psychiatric diagnosis of psychosis with diagnosis in general medicine allowed the status of a person's experience of distress to be more easily conceptualised as biomedical (Stevens & Harper, 2007).

**Extract 12:**

Res: Do you see then as trauma being different, playing different roles in each of them [Schizophrenia and PTSD] or, erm?

Dr F: No I think the role trauma plays is probably similar, but the illness is what's different /Res: right/ so the diagnosis, treatment and outcome of schizophrenia would be quite different obviously to depression or P_, PTSD, so the different pathways, totally different emphasis on medication perhaps someone with depression after PTSD may not need medication

> at all /Res: mmm mmm/ they'd just need maybe the right kind of psychological therapy. Whereas with schizophrenia you're probably going to want to give them medication as a core part of the treatment /Res: mmm mmm/ you know not the only thing, but certainly it would be /Res: yea/ a large part of it. So, in a way it's like any illness, you know, the treatment of say, I don't know, an ulcer is going to be different the treatment of erm, an overactive thyroid /Res: mmm mmm/ so it's a bit similar in psychiatry, particularly for conditions that are different. Schizophrenia and PTSD are, or depression (873-885).

In this extract, the psychiatrist compares differences between 'PTSD', 'Depression' and 'Schizophrenia' to differences between an 'ulcer', and an 'overactive thyroid' (lines 875 - 882). By using such an analogy, several rhetorical functions can be performed. First, this comparison constructs mental health diagnoses as real medical conditions, i.e. as illnesses. This construction not only legitimizes these forms of human distress, but also the need for medical intervention such as 'medication as a core part of treatment' (line 879) (Stevens & Harper, 2007). Furthermore, this analogy draws upon an evolutionary discourse that constructs mental disorders as something that is of/in the body that is failing to perform as it was designed to do so (Wakefield 1999, Boyle, 2002a). Since dysfunction has been inferred, modification is legitimated through treatment with 'medication' or 'psychological therapy' (lines 877, 878). Throughout, qualifications are offered - such as 'you're probably' and 'part of' - which have the effect of introducing tentativeness to the treatment formulation, allowing the psychiatrist to argue, if questioned, that they are not rejecting psychological approaches for psychotic experiences.

Key to this discursive device is the comparison that the 'treatment', 'diagnosis' and 'outcome' of 'Schizophrenia' as being 'quite different obviously to depression or P, PTSD' (lines 874-875), with the treatment of physical health problems, saying 'illness, you know, the treatment of say, I don't know, an ulcer is going to be different the treatment of erm, an overactive thyroid' (lines 881-882) In doing so there is an implication that assumptions of physical medicine can be applied to psychiatry. In this case a key assumption being the need to make a differential diagnosis in order to determine the correct treatment. Therefore, the use of this analogy implies that

there is a clear way of making a differential diagnosis between 'schizophrenia', 'depression' and 'PTSD', as there is for an 'ulcer' and an 'overactive thyroid', one that relies upon an objective test as in physical medicine, for instance the measuring a physical marker such as direct observation of an ulcer, or measuring thyroxin levels in the blood (Boyle, 2002a). However, in psychiatry there are no pathognomic signs or symptoms by which to objectively verify diagnoses as 'schizophrenia' (Cape et al., 1994). Instead, behaviour is observed and it is assumed that certain types of pattern will be found which correlate to a diagnostic construct (Boyle, 2002a). Furthermore, by equating of mental and physical illness, a medical pathology framework is invoked, which views the distressed individual as acted upon by impersonal forces, and is therefore incompatible with an agential framework which views that individual as a protagonist in a their life story (Jacobs & Cohen, 2010), It is possible the use of this analogy in the accounts links to a wider discourse of professional identity and reflects the importance to the status of psychiatry as a profession or scientific discipline to be seen to adhere to similar principle of physical medicine (Boyle, 2002a).

In relation to 'schizophrenia', the psychiatrist uses the sentence, 'you're probably going to want to give them medication as a core part of the treatment' (line 880), which implies a number of subject positions including: doctor, patient, treatment and cure (Harper, 1996). This phrase sets up this treatment decision as consensual, non-contested and as the taken-for-granted approach. In this extract, such an approach to treatment has been made to seem reasonable by constructing a 'schizophrenia' object as both publicly and professionally accepted through the everyday language of medicine, and as analogous to physical health problems. Therefore, if certain behaviours are symptoms of schizophrenia, then schizophrenia must lie behind them and then must in some sense 'exist', and if it can be treated, it must in some sense be capable of modification presumably through medication (Boyle, 2002a, p. 211). However, the assertion of the equivalence of psychiatric and medical illness ignores the power of psychiatrists to use psychiatric treatments coercively with the attendant lack of choice and, therefore, agency of those being 'treated' (Bracken and Thomas, 2001).

### 3.3.2. The technical and flexible use of aetiology

A second discursive resource noticed in the accounts was the flexible use of aetiology to preserve the biomedical assumptions of 'schizophrenia', whilst providing a space to acknowledge trauma in relation to psychosis. This spectrum was used in various ways in order to delineate psychotic presentations that were 'more or less' trauma related.

In this extract, the psychiatrist provides a rationale for decontextualizing emotional distress in one diagnosis but not in another. In one instance discussing emotional distress in terms of a person's trauma history, in another instance rejecting the relevance of the person's trauma history and instead advancing an explanation based upon existing pathology (Jacobs & Cohen 2010).

**Extract 13:**

Res: Would you, is that because, I guess is there, is there, different aetiological models at play there /Dr G: mmm/, that for something that has symptoms that look like schizophrenia, that that have got someone that diagnosis, is that considered aetiologically different /Dr G: mmm/, than someone who has what might be considered psychotic symptoms, but they look very close to a trauma that you can identify, that it's, that they've either disclosed or identified, are there two, are they considered to be very, two, different aetiologically, two different things?

Dr G: Yes, yeah, I would say so, erm, suppose someone has first rank symptoms /Res: uhuh/, yeah, er like thought broadcast /Res: yeah/, people can read my mind or people are taking away my thoughts /Res: uhuh/, they are making me do this, erm and if you have certainly established those symptoms, I wouldn't have a hesitation in saying look they have schizophrenia, but that does not mean that they do not have significant trauma, they might still do, but aetiologically in my mind they are different to people whose symptomatology reflects the trauma,/Res: uhuh/, in a way it's a kind of neurotic psychotic spectrum ,where they're more in touch with their trauma, whereas in the psychosis they are totally,

> you know, the content may reflect in some people , but at least its more enclosed and in touch with the trauma, and in other people it's totally displaced, it's totally taken over by something else (448-474).

Here, in response to a question regarding the use of different aetiological models, the psychiatrist draws upon a spectrum of aetiology based upon how much a person's symptoms 'reflects the trauma' (line 468). This spectrum positions a pure pathological biological disease state at one extreme pole, namely 'schizophrenia' or 'psychosis' (lines 467, 470), and pure pathological psychological state at the opposing extreme, namely 'neurotic' (line 469). The psychiatrist first presents a number of phenomena in a four part list, including: ' thought broadcast', 'people can read my mind', 'people are taking away my thoughts', and 'they are making me do this' (lines 460-463). Such lists have been noted to have a powerful rhetorical function when constructing factual accounts, in this case the constructing of 'schizophrenia' as an apparently objective diagnosis through presenting a list of symptoms (Edwards & Potter, 1992).

In this narrative the psychiatrist draws upon a biomedical discourse; first by describing examples of a person's experience, such as 'people can read my mind' or 'taking away my thoughts' (lines 461-462), as symptoms, in this case 'first rank symptoms', from which a diagnosis of 'schizophrenia' is inferred (line 460). In doing so, this narrative constructs the impression that these observable phenomena are the indicators of a pathology that exists within the individual, this may represent what the psychiatrist refers to as 'something else' (line 474) (Harper, 1996, 1999). Therefore through reference to 'first rank symptoms', this construction gives agency to the individual pathology, and positions contextual influences as non-agentive, and provides a rationale for decontextualising emotional distress.

Simultaneously, this apparently 'taken for granted' construction of an archetypal biological disorder, namely 'schizophrenia'(line 465), is deployed alongside a narrative that draws upon psychoanalytic theory to construct a 'psychosis' where trauma occupies a causal position and is positioned at a 'neurotic psychotic' pole of a spectrum (line 469) (Boyle, 2002a, Johnstone, 2011). This construction appears to have several effects; first, the challenge posed by trauma to the concept of

schizophrenia representing a primarily biological illness can be inoculated by a shift to a trauma related psychosis, here by stating 'aetiologically in my mind they are different' (lines 466-467). Second, a challenge to the biomedical assumptions of schizophrenia that is posed by obvious trauma content, namely 'symptomotology reflects the trauma' (line 468), is met by a move to a ‘neurosis’ (line 469) and therefore a psychoanalytic model. This appears to represent antagonistic agential frameworks regarding the role of trauma in this extract. An effect of invoking an individual pathological framework is that interest shifts from *story* to mechanism. So when 'schizophrenia' pathology is referred to, the person has become distressed because of impersonal causal processes, in this case 'first rank symptoms' (line 460), therefore their experience of trauma is irrelevant. In the second agential framework the person is distressed *because* of something, namely 'trauma', therefore their 'symptomatology' and 'neurosis' is influenced by their story (Jacobs & Cohen, 2010). However, even with this apparent shift in aetiological models there is no challenge to the normal/pathological and individual/social oppositions, given that the content is still seen as within the individual and representative of a pathological state given they are viewed as 'neurotic' (line 469) (Harper, 1999).

### 3.4. The Construction of the Role of Psychiatry and the Effects on the Treatment of People Labelled 'Psychotic' in the Context of Trauma

The previous sections have explored how when constructing the role of trauma through discursive resources derived primarily from biomedical discourse, a picture of trauma's relationship with psychosis contains certain assumptions, expectations and legitimates practices and subject positions (Harper, 1996, 1999).This section considers the influences on the practice of psychiatrists constructions of the role of trauma in relation to psychosis that were explored in the previous sections. There is a focus upon the analysis of the interviews in the context of wider cultural and professional culture, with a central theme being the forms of intervention carried out by psychiatrists in the lives of those in contact with services as a result of a diagnosis of psychosis

There were two dominant forms of professional intervention or response to experiences of trauma by the people using psychiatric services for experiences labelled as psychosis. These involved risk management and the provision of diagnosis and treatment.

### 3.4.1. The professional alignment with medicine as defining treatment approaches

A variation of discourse that privileged medication in the practices of psychiatry with people with a diagnosis of psychosis in the context of trauma draws upon the discourse of professional alignment with medicine. Here the psychiatrist is positioned at a professional and institutional level as being required or obligated to work within a particular professional framework of understanding and associated vocabulary, one which generally accepts empiricist discourse, and the apparatus of diagnosis and treatment (Coyle, 2007).

**Extract 14:**

Res: I'm thinking about the things that might influence you're the way you might see things [aetiology], as opposed to say for instance, the other professional, who might be more likely to, might do like you say to er re-diagnose someone as personality disorder, or having a, has personality, as having a label of personality /Dr G: trauma related/, what's been most influential on kind of, maybe, the way that you? (514-520).

Dr G: I have a medical background, one of the treatments I give is medication /Res: uhuh/, yeah, so say if I was psychologist, it doesn't matter to me whether this person has schizophrenia, whether this person has personality disorder or it really doesn't matter, what I'm doing is looking at all the influential factors that's affecting their behaviour, /Res: uhuh/ their experience, and erm their affect, you know if you take away CBT type model or even psychodynamically, which is looking at understanding the person based on their experiences, etcetera etcetera, so why does it matter if it is psychosis or personality, why should it matter /Res: mmm/, so it allows you to be more broad /Res: mmm/ in your

> thinking and give equal weightage to all your patients /Res: mmm/, but unfortunately or fortunately my profession is different, so I have to use medication /Res: mmm/ so if I believe, and this is my experience as well (524-540).

In this account, the psychiatrist is responding to a question regarding influences upon their diagnostic decisions. Dr G constructs a narrative of the obviousness of a professional affiliation with medicine, and the available interventions, as mediating their practices towards people with psychotic experiences in the context of trauma. Throughout the psychiatrist attempts to navigate both medical/pharmaceutical and psychological therapies narratives (Harper, 1996, 1999). In doing so they are negotiating narratives that are interested in different phenomena, one that produces biochemical effects (medication, line 525 ), and one that focuses upon the meaning of life experiences, presumably through a focus on behaviours and beliefs (CBT or Psychodynamic therapy, lines 531-532). Therefore, this account present a thoughtful liberal view of various ways of formulating psychosis and its relationship to trauma, but positions psychiatrists as constrained to a biomedical formulation by their professional alignment with the traditional approaches of medicine. A similar narrative was seen in other interviews e.g. Dr B, lines 519-539.

The psychiatrist starts out by adopting a 'one down' position with the phrase 'if I was a psychologist, it doesn't matter to me whether this person has schizophrenia, whether this person has personality disorder' (lines 526-528), again in doing so constructing the speaker as thoughtful and open minded. Through this statement a psychologist is constructed as a subject who is not constrained by diagnostic categorization, and thus is allowed greater freedom and agency to explore a patient's life experiences and context. The psychiatrist goes on to give the impression of this being a beneficial, or positive, feature of a psychologists role by saying, 'so it allows you to be more broad in your thinking and give equal weightage to all your patients' (lines 535-537). This 'diagnostic free' subject is contrasted with a subject who is professionally from a 'medical background' and is implicitly constructed as having to rely upon diagnosis as a means to justify the administration of medication, 'but unfortunately or fortunately my profession is different, so I have to use medication' (lines 537-539). Therefore, here agency is given to a diagnostic object (e.g.

'schizophrenia') which represents an illness with internal pathology that necessitates a chemical approach, specifically 'medication' (line 539). This assertion that a diagnostic category is an indicator for professional intervention renders a survivor of experiences of trauma as a 'damaged, helpless person' who is in need of medical or psychological technology to facilitate their return to 'normality' (Patel, 2011, p.430). Additionally, this account warrants the continued use of medication as the primary method of treatment and the position of psychiatry as the administering professionals, with psychology being positioned as independent of diagnosis and occupying the primary position in exploring the content of peoples distress, and therefore the life experiences that may be categorised as traumatic. This may represent an influence of the multidisciplinary professional approach currently advocated in modern mental health services (NICE, 2010).

As noted above, by explicitly constructing a definition of the role of a psychologist, Dr G implicitly constructs a definition of medicine indirectly saying ''my profession is different' (line 538). It is possible that such an implicit construction allows more flexibility to challenges, particularly given the highly contested topic of the role of trauma in the aetiology of psychosis. Following this implicit definition of medicine, Dr G shifts from saying the 'one of the treatments I give is medication'; to a statement that implies the use of medication appear inevitable, by saying 'so I have to use medication' (lines 524 & 538). This shift in treatment decision does not appear to be linked to the needs of the person, but rather identity claims about their discipline, one that appears to be bound up with legitimating the use of diagnostic categories (Boyle, 2011).

By referencing the varying approaches taken by medicine and psychology, the speaker illustrates how different subject positions allow different actions (Willig, 2008). They implicitly construct how their position as professional adherent to a biomedical framework, and the associated need to diagnose, as a 'technology of power' which limits exploration of life experiences upon distress, saying 'so it allows you to be more broad in your thinking' (line 535) (Foucault, 1988). In contrast, by drawing upon cognitive behavioural or psychodynamic narratives that warrant non-pharmaceutical alternatives and are not limited by diagnosis, saying 'whether this person has personality disorder or, it really doesn't matter' (line 527), they position

'psychologists' as the 'experts' to explore a person's adverse life experiences. One effect of this account is that it allows space for social and psychological interventions, perhaps representing the rise in cognitive behavioural therapies and the increasing involvement in clinical psychology in the treatment of psychosis (NICE, 2010). However, by creating a distinction between psychiatry and psychology, with regards to diagnosis and medication, a professional identity is constructed which places these skills firmly in the expertise of psychiatry. This may be associated with a wider discourse of professional identity and provides 'a powerful framework for mental health professionals to demonstrate the connection between science and practice' (Boyle, 2002a; Kirk and Kutchins, 1992, p. 23). Conversely, the work of psychology and therefore talking therapies is constructed as independent of diagnosis. This may represent a 'technology of power' governing how people are seen by mental health services as fragmented or separate biological, psychological and social beings, which is maintained by the division of professional approaches (Foucault, 1988).

### 3.4.2. A primary role of psychiatry being the modification of psychosis through medication

A theme in the accounts was the taken-for-grantedness of medication as the primary treatment option, a similar construction has been highlighted by Harper (1999). Constructing the problem of psychosis at a biomedical level, constrained the types of intervention provided by psychiatrists to those of chemical management of distress, and limited the acknowledgement of trauma (Harper, 2007)**.** In this case, the viability of medication as the only treatment served to position a person's experience of trauma as having little influence in the early stages of the treatment offered.

**Extract 7:**

> Res: Does that [Possibility that a person may not have reported or been asked about trauma] become a problem when you think about that actually you may have erm, kind of that you may have people who go through and are being treated in particular way and actually may be other treatments, because it sounds like perhaps a number of treatment paths for people, even though they're given [diagnosis of psychosis]?

> Dr B: It will be, it will be, I think the, the will still have you know guidelines which we're expected to follow, so I think the thoughts will be slightly different but the mainstream of treatment will be still the same so everyone every psychotic patient will get an antipsychotic, the question is what antipsychotic we will choose and er and er because they all have slightly different psychod, sorry pharmacodynamic profile and er, er whether we are keen to think about an antidepressant on top of it or mood stabiliser, things like that so erm_but that but also people who have psychosis they will get antipsychotic if they if they are truly psychotic, whether it is trauma related or not. (481-496)

In this extract, the psychiatrist is responding to a question regarding treatment pathways for people who receive a diagnosis of psychosis in the context of trauma. Dr B positions psychopathology, in this case 'psychosis', over the context and content of a person's experience during initial treatment decisions, and indicate that their position taken toward the individual is governed by, 'guidelines which we're expected to follow' (line 487) (Foucault, 1988). The psychiatrist constructs a patients trauma experiences as possibly influencing their psychotic experiences, however that the primary treatment response should be that of medication 'whether trauma related or not' (line 496). An interesting linguistic feature of this extract, is the repeated use of 'will' (lines 486, 488, 489, 490, 494), this use of the future tense has the effect of rendering the administration of antipsychotic medication as agentless and inevitable, and therefore means the psychiatrist does not have to take responsibility or make strong concrete claims about the process (Edwards & Potter, 1992).

A key feature of this extract is how Dr B alternates between two competing discursive repertoires whilst constructing their approach to diagnosis and treatment. Throughout, a sense of 'objectivity' is made intelligible through the use of an 'empiricist' discourse which operates in dualistic terms by creating a separation between the subject (e.g. 'patient') and object (e.g. psychosis) (Craven & Coyle, 2007; Gilbert & Mulkay,1984). This duality is evident in the extract where Dr B says, 'every psychotic patient', and 'people who have psychosis' and 'truly psychotic', thus

invoking a diagnostic category as if a pre-existing entity is lying inside the sufferer (lines 489, 496, 495) (Georgaca, 2013). In contrast, a 'contingent' repertoire is drawn upon which constructs the selection of treatment as  a process during which psychiatrists - as a professional collective - are active agents, and this is reflected by the statements: 'what antipsychotic we will choose' and 'we are keen to think about' (lines 490, 492). Here, the use of "we" possibly functions to manage the accountability of the speaker's views by providing a line of insulation against any criticism that personal interest or individual subjectivity play a role in the treatment decision. However, the notion of 'choice' here could be considered based upon factors that are not entirely 'impersonal' and 'objective' and therefore inconsistent with an empiricist discourse, such judgement involves the acknowledging of power in determining treatment course via less than objective and neutral judgements (Boyle, 2002a, p. 227). Dr B then invokes a 'technical' repertoire, which is closely related to an empiricist discourse, saying central to the treatment decision is 'pharmacodynamic profile' of the 'antipsychotic' and whether 'antidepressant' or 'mood stabilising' medications are required (lines 492-493) (Kirk & Kutchins, 1992). Additionally, they further go on to emphasise a sense of objectivity in the treatment process by downplaying the influence of the patients individual experiences, by saying 'whether it is trauma related or not' (line 495). The effect of using this highly specialised language is to create an impression that medication choices are based upon rational problem solving techniques (Boyle, 2002a). Furthermore, by locating the entire formulation in a discourse of professional responsibility as governed by external and abstract structures, namely 'guidelines' and talk of 'mainstream treatment' (lines 487-488), a sense of objectivity is further reinforced as subjectivity is governed by these institutional apparatus of power which oversee the practices of the psychiatrist (Foucault, 1988).

Despite the opposing natures of these discursive repertoires, the effect of this psychiatric formulation is to construct the nature of the treatment decision as based upon certain 'objective' factors and a neutral stance when making treatment decisions by talking about decontextualised 'things' rather than contextualised people. It is driven by the biomedical taken-for-granted assumption of the existence of a pre-existing entity, namely 'psychosis', and leads to the positioning of the

patients experience of trauma, as not influencing this stage of treatment. Such a construction is consistent with a biomedical understanding of psychotic experiences as meaningless symptoms of an underlying mental illness (Boyle, 2011, Georgaca, 2013). It seems that the production of empiricist accounts enables professionals to retain their scientific credentials and avoid appearing as if human interest influences diagnostic or treatment judgements, such formulations may link to a wider cultural discourse that represent a fear of being seen as agents of social control (Georgaca, 2013; Boyle, 2002a).Whilst it has been noted that contingent elements of accounts can allow an appeal to personal contextual factors in order to explain elements of uncertainty and variability in diagnostic decisions (Georgaca, 2013, p. 59).

## CHAPTER 4 - DISCUSSION

### 4.1 Study Aims Revisited

The aim of this study was to explore how the relationship between 'trauma' and 'psychosis' is constructed in and through psychiatrists talk, and to identify the material and social practices enabled through these constructions (Willig, 2008; Harper, 1999). The main research questions were warranted by the lack of contextualised psychiatrist accounts regarding the link between trauma and psychosis, despite the ever increasing evidence of high rates of childhood sexual and physical abuse in people who have received diagnoses of psychosis (Johnstone, 2011; Read, 2004).

The primary research aim was addressed by presenting a reading of psychiatrists' accounts whilst they explored the link between experiences of trauma and psychosis. It was apparent that medical discourses of diagnosis and classification, and the associated biomedical assumptions, were drawn upon during descriptions of both the concepts of psychosis as well as trauma. Despite the increasing common use of the term 'trauma' among professionals, its ambiguous use, and lack of clarity in this study failed to convey the complexity of the many adverse experiences that have been linked to the distress labelled as 'psychosis' (Johnstone, 2011; Read et al., 2007). Furthermore, descriptions relying upon the technology of psychiatric classification privileged assumptions of individualism and internal pathology, consequently functioning to limit the potential influence of the trauma discourse on the contextualising of peoples distress, and by positioning the individual as 'damaged' led to little acknowledgment of the perpetrators of abuses (Patel, 2003; 2011; Johnstone, 2011). The variability in the constructions of the terms 'trauma' and 'psychosis' were consistent with those suggested during a review by Boyle (2006), who suggests they enable the systematic avoidance of acknowledging life experiences in peoples distress, therefore having implications for research, aetiological models, and practices relying upon these categories.

Throughout the interviews the categories of psychosis, and in particular schizophrenia, were often presented uncritically as 'brain disorders' (Boyle, 2002b; Read et al., 2004). Such constructions positioned biogenetic factors as dominant in

the aetiology of a person's distress, and by implication positioned psychosocial factors as symptoms or consequences of these illnesses (Pilgrim, 2002). This finding is consistent with findings presented in the attitudes literature which indicate a biologically based aetiological model of schizophrenia was most strongly endorsed by psychiatrists (Harland et al., 2009; Cape et al., 1994; Magliano et al., 2010). A common feature of this biomedical construction was the dominance of a vocabulary of meaningless symptoms, individual vulnerabilities, and reliance upon context-lite language such as 'trauma'. This had the general effect of minimising the importance of a person's context and life experiences upon the distress and problems categorised as psychoses (Boyle, 2002a, 2011). Furthermore, the constructing of diagnoses of psychosis through the language of medical pathology frameworks, such as employed by the DSM, led to incompatibility with a view of a person's distress as meaningful and understandable in the context of their lives (Jacobs & Cohen, 2010). Despite the lack of available mainstream empirical evidence for these aetiological positions, their plausibility and factuality was maintained by a variety of 'scientific' empiricist discourses, such as reference to neurotransmitters (Boyle, 2002a, 2002b; Bentall, 2003).

The research question was also addressed by exploring how biopsychosocial aetiological models were variably drawn upon to construct the relationship between trauma and psychosis. The use of this discursive repertoire appears consistent with suggestions that the biopsychosocial model, along with synonyms such as 'vulnerability-stress' and 'diathesis-stress', are commonly drawn upon in psychiatric services (Read et al., 2004). Additionally that through multi-factorial accounts, psychosocial factors - including experiences of trauma - were incorporated into what in essence was a biomedical model (Dillon et al., 2012; Pilgrim, 2002; Harper, 1999). These constructions were inter-penetrated by social practices and 'technologies of institutional power', and determined the kinds of objects (e.g. trauma as a trigger) and subjects (e.g. psychotic) which were constructed (Foucault, 1982; Harper, 1996, 1999). Thus supporting suggestions that the reification of biomedical aetiology has led to the dominance of this way-of-seeing aetiology amongst psychiatric professionals (Georgaca, 2013; Harper, 2013).

Of particular interest to the aims of this study was the apparent influence of the disclosure of traumatic experiences upon the discourse of diagnosis drawn upon by the psychiatrists and, by implication, the services and approaches to treatment a patient would receive. It was noticed that, if to the 'expert' listener the content of 'symptoms' were identifiable as 'reflecting' adverse experiences of trauma, distress was perceived as aetiologically psychological or as a psychological trigger to a biological illness. Furthermore, certain diagnoses were viewed as compatible with an agential framework such as, personality disorder, or a neurotic disorder, and therefore necessitated psychological intervention (Jacobs & Cohen, 2010). In contrast, if the content of a person's experiences of distress to the listener was considered bizarre and not obviously linked to past experiences of trauma or abuse, it was likely to be perceived as aetiologically biomedical (Boyle, 2002a). This highlights how psychiatrists attempts to acknowledge interpersonal or social factors in distress by drawing upon the empiricist and rationalist paradigms offered by psychiatric diagnosis, privileges individual pathological explanations and therefore maintain the individual-social dualism (Georgaca, 2000; Harper, 1996).

This possible influence of a psychiatrists interpretation of whether a person's 'symptoms' are consistent with 'trauma', raises concerns given the various suggestions that a person's recounting of the experiences may be extremely contradictory, highly emotional and fragmented, which can often undermine their credibility (Herman, 1992). Furthermore, research has strongly implicated avoidance of recalling particular events, as well as, the role of dissociative experiences in leading to under reporting or misperception (Macfarlane 1995). Added to this, Georgaca (2000), in relation to the category of 'delusions', suggested that it is debatable whether a clear distinction between plausibility or implausibility, truth or falsity, of subjective statements can be sustained and in terms of clinical practice and questions the capacity of clinicians to make such judgments. Furthermore, such decisions appear contingent upon a variety of subjective variables, including the psychiatrist's experience, training background and even age (Cape, 1994; Harland et al., 2009).

The second research question was to identify the various subject positions enabled by these constructions, and to provide insights to the institutional practices acting on

psychiatrists in these services shaping responses to people diagnosed with psychosis who have experienced trauma.

The accounts of treatment approaches to psychosis appeared to draw upon a range of unarticulated biomedical assumptions which functioned to construct those positioned as 'psychotic' as individually pathological, as opposed to experiencing distress as a reaction to traumatic events (Harper, 1996, 1999;). Consequently, a decontextualised individual was constructed as the target for interventions based upon the modification of internal biological pathology (Boyle, 2002a). This was consistent with Harper's (1994, 1996) accounts of treatment decisions, which drew on both contingent and empiricist discursive repertoires with competing effects. Whilst a contingent account allowed acknowledgement of contextual factors, a professional alignment with the technologies of medicine and therefore notions of impersonal, neutral and objective treatment decisions, favoured an empiricist discourse which allows retention of their scientific credentials (Georgaca, 2013).

Several of the accounts constructed the reasonableness of psychosis as an illness modifiable through the practices of medicine. These included the use of medical metaphors to assert the equivalence of psychosis with medical pathology. Among the effects of such constructions was the legitimization of the management of apparently meaningless behavioural manifestations (or symptoms) through primarily chemical interventions, and the assessment of human distress by an 'expert' (Boyle, 2002a; Jacobs & Cohen, 2010; Moncrieff, 2011). This is consistent with concerns that DSM through its many editions has redefined understandable reactions to life circumstances as 'illnesses', with these then becoming the target of a variety of medications (Johnstone, 2011). A key finding was how the use of the technology of diagnostic constructs had the effect of removing; meaning from a person's experience of distress; personal agency ('sick role'); the role of social context. This ultimately led to a diversion of professional attentions away from how and why people are subjected to the distress of abuse and/or neglect (Patel, 2011). Furthermore, this shifting of a person from an agentive person with problems to a position of being a passive victim of pathology, is consistent with research highlighting that the majority users of mental health services are not asked about sexual or physical abuse (Rose et al., 1991; Read et al., 2006). Additionally it

appears to reflect the concerns that diagnosis has a number of medical and social consequences, many of which can be viewed as damaging to a distressed person (Boyle, 2002a; Harper, 1996, 1999; Georgaca, 2013).

In general the analyses sheds light on an apparent tension between social/individual and normal/pathological oppositions in the psychiatrists' constructions of the relationship between trauma and psychosis (Harper, 1999). This appeared to result in a difficulty in seeing an individual's distress as both embodied as well as simultaneously interlinked with society, and possibly represents the reification of models which privilege a somewhat decontextualised embodied understanding of distress with a reliance on a biological predisposition, such as the stress vulnerability model (Cromby et al., 2013). Furthermore, this study draws attention to the difficulty faced by psychiatrists due to a reliance on the medical framework employed by the DSM which focuses upon what happens to people based upon impersonal processes and mechanisms. Therefore, shifting any interest in a person's story to the 'mechanism' by which their distress manifests, such as symptoms (Jacobs & Cohen, 2010)

By focusing on the way professionals talk, this study has highlighted the importance of language in constructing the relationship between trauma and psychosis and in determining the kinds of objects (e.g. biogenetic psychosis) and subjects (e.g. the psychotic individual) produced, as well as that language is an active agent in this process rather than being passive (Harper, 1999). This study represents an attempt to explore some of unarticulated cultural and institutional assumptions, such as certain implied oppositions, and to map the consequences they have for professionals and those with diagnoses of psychosis. It is clear that the current understandings surrounding psychosis and its relationship with trauma remain to be maintained via a powerful nexus interconnected by apparently reasonable arguments and the apparent benefits which these provide professionals and service users (Boyle, 2002a).

## 4.2. Reflecting on the Study

This section presents an evaluation and critique in terms of a range of areas including; the methodology adopted; the epistemology that informed this study; the research process; and usefulness.

### 4.2.1. Epistemology and Methodology

A critical realist social constructionist epistemological position was adopted in this study. As highlighted, there have been several criticisms of such a position. Mainly these have arisen from epistemologically relativist scholars (e.g. Potter, 1992) who argue: firstly, that the extra-discursive can be conceptualised as a discursive accomplishment (Sims-Schouten et al., 2007; Willig, 2008); secondly, that researchers working within a critical realism framework have no systematic method of distinguishing between the discursive and non-discursive, and are therefore open to the influence of the researchers political inclinations (Sims-Schouten et al., 2007).

In this study, the analysis endeavored to develop an account of how embodied, material, and institutional factors influenced psychiatrist's deployment of particular discursive constructions (e.g. a professional association with the institution of medicine). Furthermore, the analysis involved an exploration of how these extra-discursive factors imposed constraints or made available accounts to psychiatrists, and therefore had implications for how they constructed the relationship between trauma and psychosis (e.g. a need to provide antipsychotic medication treatment) (Sims-Schouten et al., 2007; Willig, 1999, 2008).

By attempting to combine realist and constructionist positions I experienced a pull between what have been described as incompatible positions (Speer, 2007). As a result, I feel I constructed an analysis weighed in favour of a constructionist level analysis. This was due, in part, to the influence of predominantly social constructionist accounts being available as to the effects of discursive constructions, such as psychiatric diagnostic categories. But perhaps more so due to the lack of clarity as to how, and to what extent, material reality may impact upon discourse - this led to a reluctance to articulating some of my analytic thoughts (Willig, 2008). This was particularly evident when the stage of the analytic process required me to

move beyond the text and to make inferences about 'the real world'. Therefore, I feel my application of discourse analysis perhaps fails to fully explore the influence of material reality upon psychiatrists accounts of the relationship between trauma and psychosis, in favour of an exploration of how the discursive constructions available to psychiatrists determined the kinds of objects (e.g. trauma as a trigger) and subjects (e.g. psychotic) that were constructed.

Also of relevance here is how qualitative methods, such as the critical realist informed Foucauldian Discourse analysis undertaken in this study, have been criticised for being inconsistently applied, and for relying heavily on the interpretation of the researcher (Willig, 2008). This in some part may be due to the lack of precise methodological principles (Graham, 2005). I acknowledge that the focus of the discursive sites outlined in this piece of work are a product of my interpretation of the psychiatrist accounts captured during the interviews. Therefore, they are influenced by my position as a trainee psychologist with several years experience working in the area of 'psychosis', and are in line with my political motivation to produce an account that allows for a better representation of human diversity in contrast to the many normative positivist accounts (Harper, 1995). Given the lack of contextualised narratives of psychiatrist's talk whilst they explore the role of trauma in the distress of people who receive diagnoses of psychosis, as well as the dominance of positivist methodology in this area; I feel the opportunity to draw upon analytic principles in an 'ad hoc' fashion allowed me to move beyond the constraints upon thought that result from rigid methodological rules (Graham, 2005). This has facilitated the meeting of the deconstructive aims of this study, and therefore has provided space for alternative understandings of how psychiatrists construct the relationship between trauma and psychosis (Willig, 1999).

### 4.2.2. Evaluating the quality of the study

Given the diverse positions held in regard to the processes and desirability of evaluating qualitative research, I have turned to an evaluative process developed by Spencer and Ritchie (2012) which is based upon several recurring principles they believe are shared across many epistemological perspectives, and that underpin the evaluation of the quality of research (Willig, 2008).

#### *4.2.2.1. Contribution*

This principle refers to the value and relevance of the evidence produced by this piece of work. Harper (1996) argues that the process of deconstruction in mental health can play a role in challenging taken-for-granted assumptions implied within clinical categories. Therefore, throughout this study, I have attempted to provide an in-depth understanding of the way by which extremely influential workers in mental health services, namely Psychiatrist's, construct the relationship between trauma and psychosis as well as the variety of ways which these discursive constructions facilitate and constrain opportunities for action. A particularly important contribution is the description of the processes by which service users experiences may become de-contextualised through biomedical discursive repertoires. For those positioned as 'psychotic' this has implications for approaches to treatment and the meaning attributed to a person's experiences (Georgaca, 2013). For example, defining a person's distress as a disease-like diagnosis had the effect of positioning a person's context and life experience as non-agentic and facilitated the practice of obtaining treatment for a biomedical source (Jacobs & Cohen, 2010).

Willig (2008) suggests that there are epistemological challenges to applying the findings from discourse analytic research, as well as whether findings can have relevance beyond the context of the study itself (Spencer & Ritchie, 2012). However despite the analysis being limited to a particular set of interactions occurring in a specific context, it can provide insights to how particular constructions are embedded in particular discursive repertoires. Therefore, by shedding light on these available discourses the analysis has wider significance to those involved with in and with mental health services. Furthermore, in conjunction with the increasing body of social constructionist informed research regarding professionals' psychiatric practices such as, diagnosis, classification, and treatment, there are grounds for the generalisability of these findings (Georgaca, 2013). Thus I will offer some implications for different interest groups in mental health including researchers, professionals and service users. These suggestions are consistent with the idea of

using discourse analysis to promote 'subversive discursive practices and spaces for resistance' (Willig, 1999, p12).

*4.2.2.2. Credibility*

Willig (2008) suggests that the association of discourse analysis with constructionist epistemology means that it would be inappropriate to evaluate this research based upon its correspondence to external conditions or contexts, such as whether it is corroborated by other research. This study is a discursive construction and therefore can only be evaluated in terms of its 'internal coherence, theoretical sophistication and persuasiveness' (Willig, 2008, p.156).

Given that there are epistemological challenges to applying the findings from discourse analytic research, as well as whether findings can have relevance beyond the context of the study itself (Spencer & Ritchie, 2012), the principle of credibility adhered to here refers to the defensibility and plausibility of the claims made by this study (Spencer & Ritchie, 2012).

In order to fulfil this criteria I have been transparent throughout as to the research process I have adhered to thus allowing the reader to assess the plausibility of the claims made. This is evidenced by: the explanation of the development of the study aims and a clear explanation of the analytic process followed (section 2.10); providing clear and comprehensive accounts of the labelling and categorizing of the phenomena focused upon during the analysis; by displaying extracts of the raw data from which the analysis was made (Willig, 2008) . Additionally, throughout the analytic process I met regularly with my research supervisor who scrutinised the analysis and questioned assumptions made about the data, particularly, when they appear to stray from the talk recorded in the transcripts.

*4.2.2.3. Rigour*

Spencer and Ritchie (2012) describe that this principle is concerned with 'the appropriateness of research decisions, the dependability of evidence and the general safe conduct of research' (pp. 231). In order to be make explicit my relationship with the study, a reflective diary was kept throughout, in which I was able document influences upon study decision (appendix 8). Also I have attempted to be

reflexive through continuous scrutiny of the study processes and my role throughout the study, this is considered in the reflexivity section of this chapter.

I have endeavoured to declare any guiding values and the theoretical orientation adopted in this study, in particular the critical realist social constructionist epistemological stance. In addition, I have provided a description in section 2.10 of how the transcripts were analysed and provide a section of transcription including the coding as an example of the categorization process (appendices 7 & 9). This allows the reader to take this into account when reviewing this study and any claims made as to what the transcripts represent (Willig, 2008).

### 4.3. Reflexivity

In contrast to positivist research, social constructionist informed research holds that subjectivity influences all forms of knowledge and therefore attempts should be made to recognise and account for such influences (Henwood & Parker, 1994). Therefore, here there is a consideration of the researcher's contribution to the construction of meanings throughout the research (Willig, 2008).

#### 4.3.1. Data collection

The controversial nature of the question being asked by this study appears to have had an influence upon the recruitment of willing psychiatrists. A notable reason for psychiatrists declining to participate was scepticism as to the motivation of the researcher conducting the study, with several raising concern that the study may be an attempt by a 'Psychologist' to discredit the role of psychiatry in the area of psychosis. Such a concern may well have been compounded by the political context at the time of conducting the research, with the much anticipated release of the DSM-V nearing, there was increasing attention focused on what was being described as a 'turf war' between Psychiatry and Psychology. A further issue of collecting data via semi-structured interviews is one of the relationship between the interviewer and interviewee (Frith & Gleeson, 2012). In particular, the 'stake' and 'interest' of both participants and the effect this had upon the data produced. (Potter & Hepburn, 2005, p.295). For instance, certain responses regarding diagnosis from the participants may have been a result of anticipated criticism from the interviewer

(a trainee psychologist who might be expected to have different views on diagnosis). Although claims of representativeness are not being made by this study, it is likely this limited the versions of the trauma and psychosis discourses mapped during this study. In addition, this may say something of the psychiatrists who agreed to take part in this research, such as their familiarity with the area.

Harper and Thompson (2012) caution that interviews have become the preferred method of data collection this is despite a set of problems which are difficult to eliminate, such as issues of interest (Potter & Hepburn, 2005). It is suggested that such issues could be avoided through the use of alternative 'naturalistic' data collection methods such as, recording case discussions or reviewing case notes (Potter & Hepburn, 2005). The aim of using such data would be the avoidance of active researcher involvement and therefore the interactional issues associated with interviews. It is possible naturalistic records may have led to novel questions and issues arising that may otherwise have been limited by the interviewer's agenda. Furthermore, the audio or video recording of case discussions may have allowed consideration of questions, such as whether psychiatrists variably construct the relationship of psychosis with trauma when speaking with different professional groups. However, it should be noted that such methods pose the challenge of it being harder to explore research questions exhaustively due to a lack of direction from the researcher.

### 4.3.2. Challenges of the analysis process

A major difficulty faced was representing the interaction between the interviewer and interviewee in a way that prevented extracts being taken out of context. Often the extracts of particular interest to me were embedded in lengthy unfolding narratives, which commonly included evolving monologues provided by the psychiatrists (obviously with some encouragement). In attempting to ensure the extracts are contextualised, I have included interactions and various interjections (Potter & Hepburn, 2005). In addition, I have attempted to orientate the reader to the context of the interview question by prefixing each analytic area with a brief explanation of what was being spoken about at the time. However, given limitations on word count, I acknowledge that these steps may not allow the reader to make a full evaluation of

what was said independent of the one presented, which is strongly influenced by my own theoretical assumptions.

During the interviews I held a dual position as both a researcher and a Trainee Clinical Psychologist who was, in many of the cases, working locally and so known to the Psychiatrists professionally. Therefore it weighed on my mind throughout the research how my interpretation of the words of the psychiatrists would be seen by those interviewed, many of whom I would likely work closely with in the future. I therefore felt a great responsibility to those who had taken part, as well as fear as to how my analysis might be perceived. Many authors have identified that ethical issues involved in interpreting the words of other. Kitzinger and Wilkinson (1997) highlight that researchers will have a preference for how the accounts are written with particular aims in mind. I have attempted to make these aims explicit throughout this research, whilst being mindful of my power relative to the interviewees to interpret their words. Furthermore, the aim of using a critical realist analysis informed by Foucauldian principles to interpret the psychiatrists' accounts was not an attempt to discover or map the 'true nature' of psychological phenomena or psychiatrists 'minds'. Instead the aim was to explore the discursive worlds they inhabit as well as the social, psychological and physical effects of these discourses (Willig, 2008). This work itself represents a discursive construction and presents one of numerous possible interpretations of the accounts (Willig, 2008). As such, during the analysis it was important to remain mindful of the context of accounts as a product of an interview between a psychologist and psychiatrist, and how this research process has shaped the findings.

Approaching the analysis with research questions and guiding concerns, although crucial, at times did not feel sufficient. This was compounded by being a researcher who was making the transition from only having previously conducted research from a quantitative and naive realist position. Key to this uncertainty was the absence of formal or 'objective' analytic principles, with instead academic texts providing 'methodological signposts' to be applied to the analytic process (Arribas-Ayllon & Walkerdine 2008, pp. 98). However, throughout the process I sought support in the comments of my academic supervisors and fellow trainees using similar approaches, who also spoke of a sense of despair and feelings of complete incompetence at

points during their analysis. Eventually, through the support and knowledge of my supervisor, and the reading and rereading of research that has adopted a similar approach, I was able to produce an interpretation of the interviews. One that at this point in time feels sufficient.

The process of doing 'discourse analysis' has been a challenging one. However, it has highlighted to me the need for both personal and epistemological reflexivity throughout the analytic process. The process of reflexivity alerts us to how our observations and interpretations are influenced by us as observers, and by our relationship to what is being observed (Parker, 1999). Through the analysis of the interview accounts, my awareness has been drawn to the constructive nature of language and the influence this has upon the findings. Not only is this apparent in how the language used to guide the interviews may have influenced the responses of the interviewees, but also how reading and re-reading of existing discursive analytic research has influenced my interpretation of the data. Therefore, although it is crucial to familiarise oneself with existing literature, caution should be taken not to simply reproduce it. This may be avoided by constantly reflecting upon interpretations as well as ensuring these are evidenced by the extracts (Willig, 2008).

### 4.3.3. The use of taken-for-granted language

As a clinician in training, this research process has been extremely powerful in drawing attention to my need to be constantly aware of the evolution of language within mental health settings. This was initially made acutely obvious to me whilst asking questions during the interviews. Although primarily influenced by my research interests, and myself being dominant over the direction and structure of the conversations the interviews were physically and discursively located within psychiatry making it difficult to avoid taken-for-granted psychiatric language when developing questions in the interviews, particularly when adopting a journalistic style. The preference for this use of language perhaps demonstrates the ease that psychiatric language creates in communication between two professionals, additionally, to not use such language may be considered as lacking in knowledge in the field, certainly I felt this way at times (Boyle, 2011). This perhaps reflected, not only my training and experiences within psychiatric institutions that privilege the use

of particular language, but also how these constraints on what can be said further produces certain kinds of knowledge (Soyland, 1994). The result was that many of the assumptions of such language were not fully explored in the interviews, compounded by the lexical relationships between many of the terms in psychiatry (Terre Blanche, 1995). This limited the available data for analysis and therefore required greater deconstruction within the analysis, again it was only possible through the support of my supervisor, who continually reminded me to, "Shine a light" and remain curious about the language used within the talk with the psychiatrists.

As a clinician currently working with in a system that privileges discourses of individualisation, pathology, abnormality, and diagnosis, it was extremely difficult to notice, let alone unpick, the 'taken for granted' constructions in psychiatric language and discourse. This highlighted to me how ingrained these discursive repertoires are and how influential they have become upon thinking, including my own. Although, the process of doing such a piece of work has highlighted to me that dominant discourses can be extremely limiting, by sensitising me to the productive nature of language it has provided me with a greater understanding of the use of language in clinical practice, and that the there is great possibility for change and alternative understandings (Harper, 1996).

### 4.4. Implications

The findings of this study, along with the literature reviewed in the introduction to this research, indicate dominant biomedical and psychiatric discursive repertoires have maintained the status quo within mainstream mental health services, and in addition, have minimised challenges to dominant paradigms (Harper, 1999). I have included some implications that are consistent with the analysis for different interest groups in mental health including researchers, professionals and service users. These suggestions are consistent with the idea of using discourse analysis to promote 'subversive discursive practices and spaces for resistance' (Willig, 1999, p12).

Although this study was concerned with complex social and psychological processes involving the negotiation of meaning and interpretations among the

participants, the findings are consistent with a number of other studies therefore there are modest grounds for generalisation (Willig 2002).

### 4.4.1. Research and theory

The discursive repertoires drawn upon during this study highlight the current dominance in mainstream psychiatry and psychology of the assumption that the focus of research and theory should be, 'decontextualised individuals, whose behaviours, cognitions and emotions are best accounted for by reference to their brains or minds' (Boyle, 2011, pp. 34; Dillon et al., 2012). It is possible a shift from this positivist empiricist research paradigm, which relies upon unrepresentative categories, may facilitate the availability of theoretical paradigms through which professionals can attempt to explicitly link the social and the behavioural/psychological (Harrop, et al., 1996). Such models could be achieved by researchers adopting ideas such as the 'lifelines' approach suggested by Rose (2001); which calls for aetiological theories that recognise how organisms and their environments are in constant interaction or interpenetration throughout life, rather than dualistic theories advocating artificial distinctions between biology, psychology and the social or contextual (Cromby et al., 2013).

In recent years, trauma-informed models have begun to draw upon available research findings to provide a contextualised understanding psychosis related experiences such as, dissociation, and hallucinations (Dillon et al., 2012; Read et al., 2005). In doing so, they provide accounts that adequately distinguish between how biology enables distress, whilst not simply reducing biology to primarily causal (Harre, 2002). Therefore, rather than treating biology as irrelevant, there should be research and theories which investigate how aspects of our biological systems are bound up with social and relational processes, rather than simply causal. By including in accounts biological features, such as neural mechanisms, whereby societal and relational influences can become part of individual subjectivity, there is greater potential for such research and resultant theories to challenge prevalent biomedical accounts (Cromby, 2003; Dillon et al., 2012). Inevitably this will involve complex theories which acknowledge the multiple origins and influences upon experiences of distress. However, this may ultimately provide professionals with

adequate discursive frameworks to acknowledge the heterogeneity of experiences with which they are faced. Furthermore, these paradigms could lead to theories that play a key role in countering biomedical formulations by making distress psychologically and socially intelligible (Boyle, 2011).

### 4.4.2. Clinical implications

This study has shed light on how the language available to professionals such as 'trauma', 'symptoms', and that of diagnostic categories, play a powerful productive role in constructing and constituting the realities of distressed people (Georgaca, 2013). Mental health professionals can play a key role in countering the prevalence of what Boyle (2011) calls context-free or context-lite language in mental health services. The apparent reliance upon language reified through diagnostic systems supports suggestions that professionals risk sounding unprofessional or strange for using 'non-professionals terms', and are uncomfortable or embarrassed to embark on detailed description of sometimes horrific abuses (Boyle, 2011, p. 41; Read et al., 2006). Given the power of language in relegating the importance of context, it too can play an equally important role in making distress meaningful and intelligible (Boyle, 2011). The following section considers some suggestions for introducing context rich language into professional practice.

#### *4.4.2.1. Formulation*

Johnstone (2013) advocates team formulation as a process of contextualising and making meaningful a person's distress. Formulation aims to draw upon a variety of psychological models and theories and attempts to integrate these through their personal meaning to the distressed person (DCP, 2011). However, as noted above, it is important to be mindful of theoretical orientations to formulation that risk simply replicating individualising pathological assumptions. In recent years there has been interest in formulation being performed at a team level (Summers, 2006). Such an approach may allow life experiences including experiences of physical or sexual abuse, to be a subject that is discussed openly in teams, and provide a framework to facilitate the translating of 'symptoms' and 'illnesses' into understandable responses to life circumstances (Johnstone, 2013). Additionally it allows an equally important focus upon the more mundane experiences which lead to emotional and

psychological distress, such experiences might include racism, social isolation and bullying etc (Boyle, 2006). Johnstone (2013), as well as several other researchers, have highlighted the approaches effectiveness in promoting psychosocial understandings and moving away from diagnostic-based plans in a variety of setting including inpatient and community mental health teams (Pilgrim, 2002).

Johnstone (2013) also advocates for team formulations to be 'trauma informed', that is to say that if there is any known history of physical or sexual abuse, or neglect, then the persons presenting difficulties should be considered as possible effects (pp.232). In addition, if a formulation does not appear to account the difficulties and distress experienced by the individual, then trauma should be explored as a possible explanatory factor. It is important to note that this acknowledgement of trauma is not an indication that trauma focused therapy should be the immediate focus of support and intervention. However, such a formulation will provide an evolving framework through which support can be provided and also provide a shared understanding between the service user and mental health team (Dallos & Stedmon, 2006). In doing so, this would make it difficult not to begin to focus upon systems maintaining abuses and neglect, therefore encouraging preventative work such as programmes to enhance child safety (Davies & Burdett, 2004).

*4.4.2.2. Education and training of professionals*

As noted in this study, the disclosure of traumatic events to psychiatrists can affect the conceptualisation of distress and the access to treatment available to service users. A study in New Zealand found that of 191 women receiving counselling for childhood sexual abuse, found the average time taken for them to tell anyone of the abuse was 16 years (Read et al., 2006). This perhaps reflects the taken-for-granted biomedical paradigms used to understand severe mental health problems such as 'psychosis' and 'schizophrenia'. Mental health workers should be supported to develop the skills to question and challenge these taken-for-granted paradigms which greatly influence practices, such as enquiring whether a person has experienced physical or sexual abuse. Educational institutions are ideally placed to provide information about alternatives to dominant paradigm of diagnosis, and the effects of individualising and pathologising human distress. Cromby, Harper, and

Reavey (2008) reported that the main available textbooks available in undergraduate courses are structured according to psychiatric diagnosis. Furthermore it is suggested that there is a strong influence of bio-determinism in psychiatry training courses (Kemker & Kvadi, 1995). This could be countered by a shift in a focus to theories that acknowledge links between power, powerlessness and mental health (Williams & Lindley, 1996). More specifically this may be facilitated by providing information about the social constructions of psychosis and the implications this has for those who receive such a diagnosis. This may contribute to providing an alternative discursive space to challenge the current dominant psychiatric notions which limit contextualised understanding of distress (Boyle, 2011).

*4.4.2.3. Clinical psychologists*

Clinical Psychology could play a key role in promoting the availability of alternative discourses. However, current mainstream psychological thinking is strongly informed by CBT approach which fail to challenge traditional assumptions of psychotic experiences, by locating pathology within the individual (NICE, 2010; Boyle, 2011). Clinical Psychologists should challenge these dominant approaches, by advocating theories and models that help those labelled as 'psychotic', who also may be survivors of trauma, to support a contextualised understanding of their distress (Johnstone, 2011). This may be achieved by offering social constructionist informed talking therapies, such as Narrative Therapy. These acknowledges the impact of the 'normal' world upon people by broadening the scope of intervention from the 'pathologised individual' to include political, socio-cultural, gender and ethnicity informed accounts of peoples distress which challenges the taken-for-granted biomedical paradigms (White, 2007). In focusing intervention at more distal levels, this may allow subversion of the association between psychosis and individual pathology, providing the potential for traumatic life experiences to be acknowledged by formulation and intervention that is rooted in a person's lived experience (Smail, 2001).

4.4.3. Users of mental health services

Interviews were not conducted with users of service users in this study, therefore many of the suggestions here will be speculative. However, given research indicating

how biomedical models held by professionals plays a significant role in transforming a person's experiences and complaints to symptoms of mental disorders; the use of language within the culture of psychiatry and psychiatric services has very real implications for those who use them (Georgaca, 2013).

Over many years the mental health service user movement has developed to become a progressive political force that provides alternative space outside predominantly biomedical psychiatric services (Tait & Lester, 2005). The availability of access to groups such as the National Hearing Voices Network have long advocated for the acknowledgement in services of the high prevalence of childhood physical and sexual abuse in those receiving psychiatric diagnosis (Dillon et al., 2012). In particular, these movements have voiced their belief that there is meaning in a person's experiences diagnosed as 'psychosis'. Such movements provide an important alternative discursive space that should be increasingly heard and engaged with by mental health professionals. Therefore, a greater emphasis should be placed on developing links with mental health services through joint training involving users, carers and mainstream mental health workers (Brunning et al., 1994). Furthermore, academic training courses as well as professional development courses should give equal weighting to texts or literature produced by users, such as writing produced by The Hearing Voices Network, as well as publications such as Asylum magazine which is produced by users and professionals working together. Additionally, future research in the area of this trauma and psychosis could focus upon service users' experiences of speaking about trauma in relation to receiving a diagnosis of psychosis. This may allow professionals to be influenced by ordinary context rich language as opposed to psychiatric decontextualised psychiatric jargon.

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## Appendix 1 - Literature Search Terms

Search: EBSCO

Psych info and psych articles. Searched psychiatrists AND attitudes AND psychosis, dates 1970 -2012. Returned 113 results. Refined by presence in title of attitudes and psychosis – included opinions and views in title. After refinement 19 articles remained. Additional relevant articles were selected through cited references in papers.

# Appendix 2 - Ethical Approval

SCHOOL OF PSYCHOLOGY
Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.

UEL
University of East London
www.uel.ac.uk

**School of Psychology**

**Professional Doctorate Programmes**

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

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## Appendix 3

## PARTICIPANT INFORMATION

You are being invited to take part in a research study. In order to help you decide whether you would like to participate or not, please take time to read the following information carefully.

**What is the title of the study?**

How Psychiatrists talk about the relationship between psychological trauma and psychosis.

**What is the purpose of the study?**

There is little research that has looked at Psychiatrists attitudes and beliefs about the relationship between psychological trauma and psychosis. This study is interested in seeing whether the views held by psychiatric professionals about trauma and the aetiology of psychosis influence views about diagnosis, treatment and other aspects of care provided. The study is being conducted as part of the researcher's Doctoral Degree in Clinical Psychology at the University of East London.

**Why have I been chosen?**

You have been approached to take part in the study, as you are a Psychiatrist who routinely works in the NHS. We are interested in hearing about the views and experiences of psychiatric professionals who are likely to have had direct contact with people experiencing psychosis.

**Do I have to take part?**

Participation in the study is entirely voluntary. It is your decision whether or not you take part. If you do agree to take part, you will be free to withdraw any time, and you will not be asked to give any reason.

**What will happen if I choose to take part?**

You will be asked to sign a consent form stating that you are happy to take part in the study. Following this, you will be invited to attend a one-to-one, confidential interview at a time and place convenient for yourself. The researcher will ask questions about your views on the relationship between psychological trauma and psychosis. The interview will last no longer than 30-60 minutes and will be recorded and transcribed by the researcher. You will be given the opportunity to ask questions before and after the interview.

**What if I become distressed during the meeting?**

Although unlikely, it is possible that the subject area being discussed may be upsetting for you. You are free to leave the study at any time. You are also free to take a break from the interview and return when you feel able to. The investigator can also give you contact details for further support.

**What will happen to my confidential information if I decide to take part?**

The researcher will ask you to provide some basic information about yourself at the interview such as gender, age and length of time qualified. Participants' anonymity will be assured by assigning each participant a code. The codes and consent forms will be kept in a locked cabinet separate to the recordings of the interviews, transcribed materials and basic details about participants (e.g. name, age etc.). The researcher will transcribe all of the interviews. All of the identifiable information obtained in the interview will be anonymised. Only the researcher, supervisors and examiners will have access to the transcribed material. Data will be only accessed via a password on a computer, and will be erased after five years. After examination of the research has been concluded, all digital records will be erased.

What you say in the interview will be kept confidential. Small extracts of what you say may be used as quotes in the final write-up of the project though these will be anonymised. The researcher will only break confidentiality in the unlikely event that they have serious concerns about your safety or the safety of others. The researcher will try and talk to you about breaking confidentiality before they do so if possible.

**What are the risks and benefits of me taking part in the study?**

As discussed above, it is possible, though unlikely that the issues talked about in the interview may be emotional for you, and it is possible that you will think about or even re-experience difficult events that have happened to you in the past.

In terms of potential benefits, the findings of this research might help to change future experiences psychiatric services users or others involved in mental health services.

**Where will the interview take place?**

The interview will take place at convenient location for the interviewee.

**What if I change my mind and do not want to be involved in the project at a later date?**

You are not obliged to take part in this study, and are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and you do not have to give a reason for doing so.

**Ethical Approval**

This research project received Ethical Approval from the University of East London.

**Disclaimer**

You are free to withdraw from the study at any time, up to the point when the data is included in the overall analysis. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. Should you

withdraw, the researcher reserves the right to use your anonymised data in the write-up of the study and any further analysis that may be conducted by the researcher.

**Contact for further information**

Thank you for taking the time to read this leaflet. If you would like to take part or have any questions please contact Edward O'Donnell on the email below. Alternatively, you can telephone the researcher on one of the telephone numbers below.

**Researcher's details:**


Name: Edward O'Donnell, Trainee Clinical Psychologist

Contact address: Doctoral Degree in Clinical Psychology

School of Psychology

University of East London

Stratford Campus, University House

Romford Road

Stratford E15 4LZ

Telephone: XXXXXXXXXXX

Mobile: XXXXXXXXXXX

E-mail: XXXXXXXXXXX


**What if I have a query/complaint about the way the study is being conducted?**

University Research Ethics Committee

If you have any queries or complaints regarding the conduct of the programme in which you are being asked to participate, please contact the Secretary of the University Research Ethics Committee, Ms Debbie Dada, Admissions and Ethics Officer, Graduate School, University of East London, Docklands Campus, London E16 2RD (Tel 020 8223 2976, Email: d.dada@uel.ac.uk)

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**Project supervised by:**

Dr David Harper

Professional Doctorate in
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## Appendix 4 - Consent Form

**Title of study:**

**How Psychiatrists talk about the relationship between psychological trauma and psychosis**

Identification Number:

Gender: F☐ M☐

Age: 18-24☐ 25-34☐ 35-44☐ 45-54☐ 55-64☐ 65>☐

Stage of training: ……
……..

**Please initial box**

| | | |
|---|---|---|
| 1 | I confirm that I have read and understand the information sheet relating to this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | ☐ |
| 2 | I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason for doing so. | ☐ |
| 3 | I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. I understand that anonymous extracts or quotes of what I say during the interview may be written up or published. | ☐ |
| 4 | I agree to take part in the above study. | ☐ |

Name of participant:

Signature:

Date:

Name of researcher:

Signature:

Date:

## Appendix 5 - Interview Prompts

**Please note that these questions only acted as a reminders to areas to be covered.**

Prior to the interview

Following introductions, the researcher will outline what the interviewee may expect in terms of timing, structure and style of interview. Emphasis conversational style / hearing their point of view and expert understanding of the area.

Request read and sign the consent form.

Interview prompts.

Only use as a guide - use probes to explore areas further. (Define trauma as experiences of physical or sexual abuse, or neglect).

Definitional questions:

a) How would you describe/define psychosis?

- How would you describe psychosis to a patient?

b) How would you describe/define trauma?

c) What are your views on the aetiology/causes of psychosis?

- Most important factors?
- What causal models to do find most useful to draw upon in practice?
- What do you consider when making a diagnosis?
- are there causal factors that you feel influence a person prognosis/recovery/outcome?

d) What role do you think trauma plays in psychosis (aetiology of)?

- In comparison to other diagnosed e.g. PTSD/Depression?
- What influence has research linking trauma and psychosis had upon mental health services/your practice
- Is this something you ask about in practice? Routinely ask about?
- Are things you look for that would make you ask?
- Barriers to asking?

e) Treatment

- Would disclosure influence treatment options?
- Would disclosure influence diagnosis?
- Standard treatment options?

Probes:

- What made you think of that?
- Could you say a little more about that?
- What influenced that decision?
- Have you always held that view?

After the interview.

Enquire whether interviewee would like to add anything, perhaps an area they feel is important but not covered.

Seek confirmation of consent to use information recorded during interview.

## Appendix 6 - Transcriptions convention

The transcription conventions used in this study were based on a simplified version Potter and Wetherell's (1987). These were chosen given the emphasis on the readability of the content as opposed to the detailed reproduction of speech feature, such as intonation or length of pauses.

| Notation | Description |
|---|---|
| **...** | Three full stops denotes unfinished utterances |
| (.) | Pauses considered noticeable were indicated by the use of a full stop in brackets - these were not timed. |
| /text/ | Brief interruptions or encouragements were denoted by forward slashes within the dialogue e.g. /Researcher: mm okay/ |
| _ | An underscore was used to denote an absence of any noticeable audible gap between to utterances, e.g. when one speaker is interrupted by another. |
| <inaud.> | Chevrons were used to indicate points were material was omitted from the text due to being inaudible or there was significant doubts about its accuracy. |
| **[ ]** | Square brackets were used to provide descriptive information. |
| Number e.g. 0, 1 | Each transcript was formatted with wide margins and to include consecutive line number commencing at 0. |

Addition information:

Extracts were numbered in the order they appear in the analysis section.

Participants were given pseudonyms which were used to identify extracts in the analysis.

Punctuations was added to facilitate reading.

## Appendix 7 - Example of Analytic Coding Process

| Transcript (line) | Theme | Notes |
|---|---|---|
| T 2 (154)<br><br>T4 (123) - dualism<br>T6 (156) | **Continuum: Ordered vs Disordered:** Used in reference to personality disorder - Construction of normal and the abnormal the realm of psychiatry, psychosis being on the outer extreme of abnormality and therefore in need to intervention<br>**All humans slide on the scale -** severe stress in the vulnerable causes extremity - individual vulnerability | Model of individual vulnerability |
| T 2 (175-191)<br><br>T1 (420?) | **Biological vs psychological mindedness:** over biologically minded psychiatrists over diagnose bipolar and psychosis. What is this about, if more biological you believe more in the existence of these??<br>However: over psychological minded psychiatrists fail to use adequate medical intervention | What is being constructed here? Different types of people/or knowledge's |
| T2 (196)<br>T1 (605)<br>General theme<br>T 3 (286)<br>T4 (584) | **Real versus not real psychotic 'symptoms'/illness:** Idea that some behaviours and descriptions look like psychosis but are not 'real' psychosis - they are in fact 'symptoms' of other diagnosis - Example is PTSD<br>**Psuedo vs real hallucinations:**<br>**Validity of category** | The construct of real appears to represent an observable/proven biological/physical brain problem |
| T2 (208)<br>T4 (215) | **Symptoms in context of history:** The linking of 'symptoms' to history changes the 'disorder' that the symptoms represents - therefore if person able to articulate make link/ or if symptoms phenomenologically linked to past trauma then PTSD | Need to review transcripts. How do they differentiate?? |
| T 1 (217)<br><br>T2 (975)<br>T5 (287) | **Trauma:** is being associated with more 'psychological' diagnosis such as PTSD or BPD - not the more traditionally disease related diagnosis. Not in the domain of psychiatry?<br>-Not just act of abuse/event but the emotional sequelae that follow | Review transcript 7 - remember similar discourse. |
| T 2 (236)<br>General<br><br>T5 (154) | **Psychology not the realm of psychiatry:** Acknowledging trauma and impact of life events can be positioned as over psychologising and not the role of psychiatry<br>**Professional boundaries** | Influence of institutional guidelines limiting role - leading to definition of people |
| General<br>T4 (236)<br>T5 (990) | **Lack of framework to integrate:** Restricted by the idea that trauma/ life experience is very abstract whereas medicine works with the concrete the observable | Idea that trauma abstract where diagnosis is concrete |

**Appendix 8 - Extract from Reflexive Diary**

Following each of the interviews, I wrote some brief reflections. They were mainly made in brief note form. I referred back to these notes during the analysis process and during the write up of the study.

Examples:

Following interview with Dr C:

*Very hard interview. Extremely difficult to illicit any answers, perhaps reflects participants early stage of training. Responses seem very text book, he didn't appear to really draw upon his experiences that much - may have been due to wanting to come across as professional? Interesting that he closely adhered to diagnostic criteria, is this considered most professional way to communicate, maybe a language we both shared. Worth thinking about influence of proximity of training upon language/repertoires drawn upon.*

*Interesting influence of past supervisor, she appears to have at least provided some sense that there is some clinical judgement. Became much easier to talk to when he was speaking about how past supervisor re-diagnosed in the context of past trauma's. His past supervisor sounds like would be a great participant - re-send information sheet and remind to follow up.*

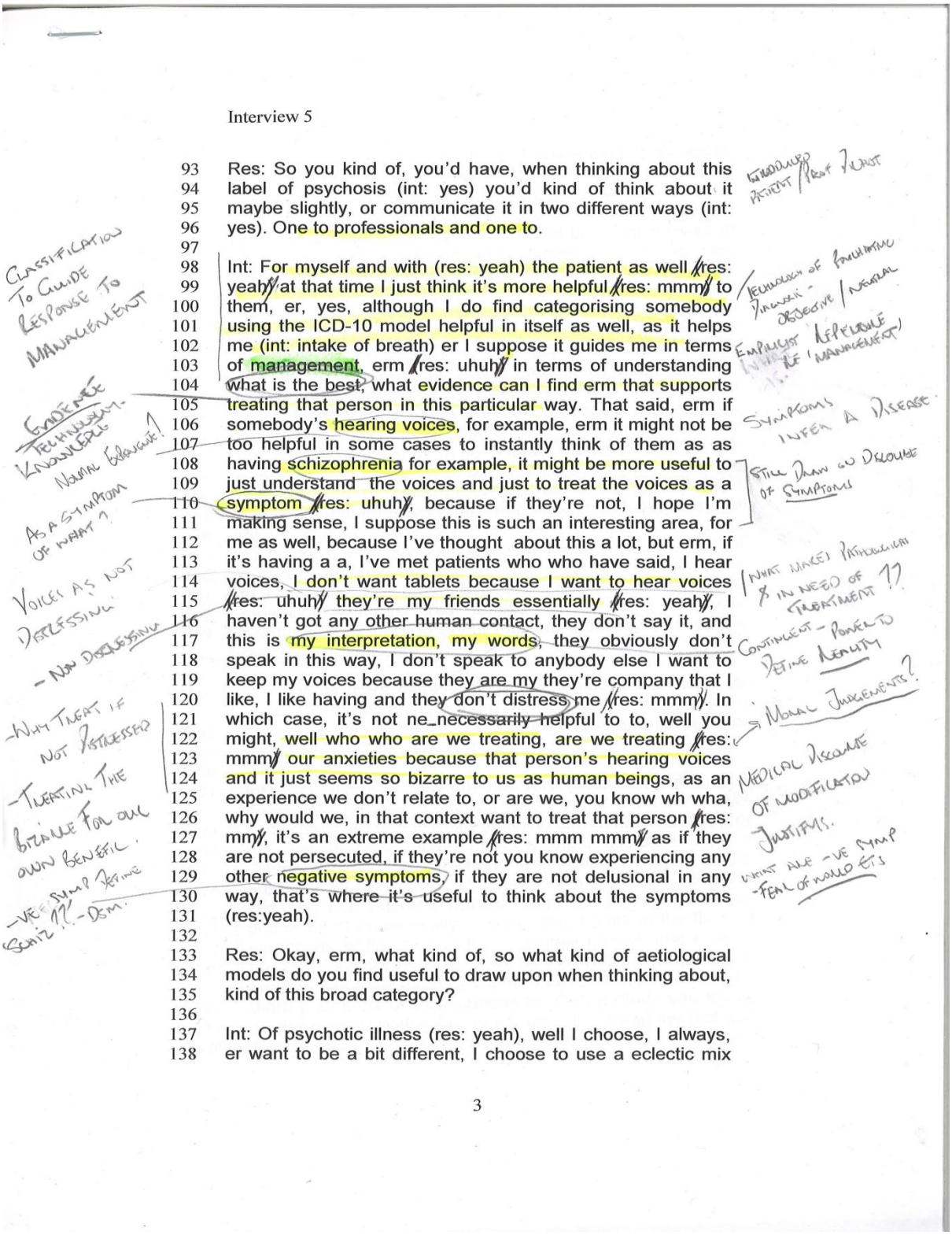
Following interview with Dr D:

*Extremely interesting interview. Interview flowed very easily and didn't really require me to do much prompting. Interesting to hear how views changed overtime with experience. key that she had been so greatly influenced by systemic training which she feels influenced her formulations - still seemed to find it difficult to step outside diagnosis - professional alignment? Interesting how she likened speaking about content to heresy when first became psychiatrist - have times changed?*

*Found myself agreeing with a lot that she said, may have stopped me exploring exactly why she had reached these views. Perhaps prevented me as questioning as should've been. Great that she was so complementary about the area of research. Interesting that she raised how psychologists risk just replicating mainstream ideas by adopting CBT model - definitely reflected her systemic training. Interesting comments she made off tape. Worth thinking about for next interview regarding being trained to listen, 'really listen' to what is being said by people when distressed. Does this reflect symptom watching/spotting?*

*Point to consider for future interview - how much do they think about aetiology/how important do they think it is? Is it something they always think about? I'm not sure it is. Given a diagnosis and rationalising treatment isn't the same thing is it?*

## Appendix 9 - Example of Transcript



Interview 5

Res: So you kind of, you'd have, when thinking about this label of psychosis (int: yes) you'd kind of think about it maybe slightly, or communicate it in two different ways (int: yes). One to professionals and one to.

Int: For myself and with (res: yeah) the patient as well //res: yeah// at that time I just think it's more helpful //res: mmm// to them, er, yes, although I do find categorising somebody using the ICD-10 model helpful in itself as well, as it helps me (int: intake of breath) er I suppose it guides me in terms of management, erm //res: uhuh// in terms of understanding what is the best, what evidence can I find erm that supports treating that person in this particular way. That said, erm if somebody's hearing voices, for example, erm it might not be too helpful in some cases to instantly think of them as as having schizophrenia for example, it might be more useful to just understand the voices and just to treat the voices as a symptom //res: uhuh//, because if they're not, I hope I'm making sense, I suppose this is such an interesting area, for me as well, because I've thought about this a lot, but erm, if it's having a a, I've met patients who who have said, I hear voices, I don't want tablets because I want to hear voices //res: uhuh// they're my friends essentially //res: yeah//, I haven't got any other human contact, they don't say it, and this is my interpretation, my words, they obviously don't speak in this way, I don't speak to anybody else I want to keep my voices because they are my they're company that I like, I like having and they don't distress me //res: mmm//. In which case, it's not ne_necessarily helpful to to, well you might, well who who are we treating, are we treating //res: mmm// our anxieties because that person's hearing voices and it just seems so bizarre to us as human beings, as an experience we don't relate to, or are we, you know wh wha, why would we, in that context want to treat that person //res: mm//, it's an extreme example //res: mmm mmm// as if they are not persecuted, if they're not you know experiencing any other negative symptoms, if they are not delusional in any way, that's where it's useful to think about the symptoms (res:yeah).

Res: Okay, erm, what kind of, so what kind of aetiological models do you find useful to draw upon when thinking about, kind of this broad category?

Int: Of psychotic illness (res: yeah), well I choose, I always, er want to be a bit different, I choose to use a eclectic mix