Critical thinking and psychiatric knowledge: psychosis as a contested area.

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Therese O' Donoghue

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Declaration I confirm that this thesis and the research reported within it, comprises my own work. It was written and submitted in part-fulfilment of the degree of Doctorate in Clinical Psychology (DClinPsy). It has not been submitted for any other academic award.

Critical thinking and psychiatric knowledge: how psychiatrists understand and engage with psychosis as a contested area

Therese O' Donoghue

Abstract

In 2014, the British Psychological Society and Division of Clinical Psychology (BPS/DCP) published a report outlining the multiple ways of thinking about psychosis or "schizophrenia" beyond a dominant bio-medical framing. They highlighted that psychosis is a contested area.

One area of contention has been the role of dissociation as a response to traumatic experiences leading to psychosis. The current literature review aimed to evaluate the role for dissociation in the relationship between trauma and psychosis. Eighteen, peer-reviewed journal articles were included. There was evidence that dissociation is an important aspect of the relationship between trauma and psychosis. The type, frequency and chronicity were found to be important factors. The mechanisms of dissociation remain to be elucidated.

The current research study aimed to engage psychiatrists in narrative accounts of their understanding of psychosis as a contested area considering the BPS/DCP report. Semi-structured interviews were conducted with 12 participants at both trainee and qualified level. Critical Narrative Analysis was used which comprises six stages. The results highlighted the role of power, the barriers to opportunities for exposure to alternative views, and the role of dialogue and reflexivity.

The Critical Appraisal considers, using a reflective account, the strengths and limitations of the current research, along with reflections on the whole research process.

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Word count

Excluding reference lists, figures and tabulated data	
Overall abstract	209
Literature review (including abstract, 224)	7,286
Research report (including abstract, 282)	12,366
Critical appraisal	3,141
Mandatory appendices	2,621
Non-mandatory appendices	2,132
Whole thesis (excluding references)	27,755

List of tables

List of figures

PART I: LITERATURE REVIEW

What is the role for dissociation in the relationship between trauma and psychosis?

A systematic review of the evidence.

ABSTRACT

INTRODUCTION Over the last decade, an increasing amount of evidence has been presented to suggest that trauma is often a significant factor in the onset of psychosis, with some suggestion that this may related to dissociation. Dissociation has been defined in different ways depending on theoretical orientation but generally refers to splitting-off, disconnection and depersonalisation or derealisation. The current review evaluates the role for dissociation in the relationship between trauma and psychosis.

METHOD Searches were conducted using several search strategies following pre-considered inclusion criteria. From initially generated records, 18 full-text, peer-reviewed articles, comprising 1,712 participants published between January 1986 and August 2016 met the established inclusion criteria.

RESULTS Examination of the literature identified some evidence that dissociation is at times an important aspect in the relationship between trauma and psychosis. Many of the articles employed regression or correlational over mediation analyses, which limited inferences about causality and thus only tentative conclusions were drawn. Where a relationship or mediating effect with dissociation was observed, it was linked to distinct types of trauma.

DISCUSSION Implications for the research are considered, which include the importance of the type, frequency and chronicity of traumatic experiences for increasing the likelihood of dissociation in psychosis. The limitations of the study highlight the need for more refined studies and longitudinal research which could shed more light on mechanisms relating to dissociation.

1. INTRODUCTION

1.2. DEFINING DISSOCIATION

There are different conceptualisations of dissociation. Within the nosological framework which includes the Diagnostic and Statistical Manual 5 (DSM-5) dissociative symptoms are described as including unbidden intrusions into awareness and behaviour with accompanying losses of continuity in subjective experience, fragmentation of identity, depersonalisation, derealisation, an inability to access information or to control mental functions that normally are readily amenable to access or control (American Psychiatric Association, 2013 pp.291). The International Classification of Diseases describes dissociation as a partial or complete loss of the normal integration between memories of the past, awareness of identity and immediate sensations, and control of body movements (World Health Organisation, 1992).

Beyond this classification model, dissociation is conceptualised as the separation of mental processes, which are normally integrated (Spiegel & Cardena, 1991). Fonagy *et al.* (2002) describe dissociation as going into a pretend mode of mentalising. Alayarian (2011), from an analytic perspective, distinguishes between healthy and unhealthy dissociation where healthy dissociation is about detachment from unbearable memories of trauma which acts as an appropriate defense. The idea is that dissociation serves initially as a protective function so that people are not overwhelmed by unbearable experiences. Unhealthy dissociation is when this defense cannot cope which leads to fragmentation and subsequently pathology. This has been put forward by several others (Dixon, 1998; Mollon, 1996; Putman, 1997; van der Hart *et al*., 2006). Where experiences are

just too devastating in their intensity, they become stored in isolation, fragmented into their various cognitive, affective and somatic states (van der Hart *et al.,* 1998).

There has been a call for more precise working definitions of dissociation which incorporates an empirically-based understanding of the underlying mechanisms (Schore, 2009).

1.3. The historical relationships between trauma, dissociation and psychosis

The prevailing understanding of the relationship between trauma, psychosis and dissociation has shifted considerably in the last 100 or so years. At one time, dissociation held a more prominent place in understanding the etiology of psychotic experiences, before it switched to being considered more of a "biogenetic disease" rather than the psychological response to adverse events (Dillon *et al.,* 2014). Pierre Janet was the first proponent of the idea that dissociation might be a response to extreme stress and that dissociation was the breakdown of otherwise integrated psychological structures (Janet, 1907). Prince (1908), described dissociation as usual developmental consolidation, and Carl Jung suggested that psychosis might result from dissociative divisions within the personality. This subsequently influenced Eugen Bleuler's conceptualisation of "schizophrenia," with emphasis on "splitting" within the mind. This latter definition is closer to the DSM-5 classification of dissociative characteristics rather than the psychoses. He suggested that "schizophrenia" might be "*the effect of a particularly powerful psychological trauma on a very sensitive person…. rather than …a disease in the narrow sense of the word*" (Bleuler, 1960, pp.300). Kraepelin subsequently omitted dissociation from his conceptualisation of "dementia praecox" despite many of his contemporaries still considering elements of dissociation to still have significant bearing in psychosis.

During the 1960s and 1970s, there was also a renowned anti-psychiatry movement associated with such pivotal figures as R.D. (Ronnie) Laing and Thomas Szasz. Laing's focus was on understanding psychotic experiences (Laing, 1961). He applied his ideas to psychiatric care, establishing the Philadelphia Association and opening Kingsley Hall in London, a setting where no anti-psychotic medication was dispensed. Szasz was more focused on how conceptualisations of mental illness are scientifically worthless and act merely as ways to engineer psychosis for its social and political uses, to ensure social conformity (Watts, 2012). Around the same time, Franco Basaglia, a radical psychiatrist, worked to eradicate asylums in Italy which he felt worsened the lives of his patients. He initiated several reforms, particularly a reduction in coercive practices. His closure of an asylum in Trieste during the 1970s marked the first time a psychiatric institution was closed for political reasons (Foot, 2014). By the 1980s although anti-psychiatry had failed to establish itself ideologically within psychiatry, it has held an enduring legacy of critical consciousness around psychiatric conceptualisation and practices, particularly those related to psychosis (Hopton, 2006).

More recently within psychiatry, there has been a movement towards a taxonomic model to understand psychopathology with distinct diagnostic categories replacing the idea of a continuum of human experience and psychological functioning. This model has arguably dominated mainstream psychiatric practice ever since. Despite the importance placed on dissociation during early the 20th century, these original writers and researchers were to subsequently place greater emphasis on categorisation and diagnosis, with the result that increasingly, this became a dominant framework within which to understand unusual human experiences (Moskowitz *et al.,* 2009).

Over the last ten years, attention has been given to the significant commonalities between trauma, psychosis and dissociative experiences, with some even

proposing that the psychoses should be re-conceptualised as dissociative ruptures attributable to stress (Dillon *et al.,* 2014). The extent to which dissociation and psychosis can be adequately distinguished is a compelling part of the argument against more mainstream biomedical understandings of psychosis, and there is little doubt that a considerable literature has emerged in recent decades which connects traumatic experiences and psychosis, with high levels of childhood trauma reported by those who have psychotic experiences (Bebbington *et al.,* 2009; Bendall *et al.,* 2008; Bentall, 2006; Campbell & Morrison, 2007; Janssen *et al.,* 2004; Kelleher *et al.,* 2013; Read *et al.,* 2005; Read & Ross, 2003; Spauwen *et al.,* 2006). This culminated in a meta-analysis which powerfully demonstrated the substantial increase in risk of psychosis following adverse life experiences (Varese *et al.,* 2012).

1.4. Lack of clarity about dissociation and diagnostic systems

Despite the extensive literature linking childhood trauma and psychosis, the role of dissociation in this relationship remains an emerging area. Ross and Keyes (2004) advocate for a dissociative form of psychosis, and demonstrate, using first-person case studies, how easily individuals with a diagnosis of "schizophrenia" can pass as typical dissociative cases, highlighting diagnostic overlaps. McCarthy and Longden (2015), contest that there is much phenomenological and etiological overlap between trauma and psychosis presentations.

Within diagnostic systems, there is a lack of clarity about exactly where dissociation interacts with other so-called diagnostic categories. The DSM-5, for example, acknowledges that dissociative disorders may be confused for psychotic disorders because the inner voices experienced in dissociative disorders may be mistaken for psychotic hallucinations. Identity fragmentation and perceived lack of control over thoughts, feelings, impulses and acts, may be confused with

thought disorder. Visual, tactile, olfactory, gustatory, and somatic hallucinations and flashbacks may also be mistaken for symptoms of psychosis. The DSM-5 has several "dissociative disorders" (APA, 2013, pp.291-307). The manual describes how the dissociative disorders are placed next to, but are not part of, the trauma- and stressor-related disorders, reflecting the close relationship between these diagnostic classes without establishing how they may be differentiated or what experiential pathways might lead to one over another. To add to the lack of clarity, both acute stress disorder and posttraumatic stress disorder in DSM-5 contain dissociative symptoms, such as amnesia, flashbacks, numbing and depersonalisation/derealisation. DSM-5 describes two key areas of differential diagnosis as "posttraumatic stress disorder" and "psychotic disorders".

Over the past twenty years the presumed clear distinctions between "disorders" have been strongly contested for their lack of reliability, validity and utility (Bentall, 1990; Boyle, 2002). The taxonomic model within psychiatry has been challenged for its continued emphasis on discrete psychiatric conditions and its pervasive misunderstanding of the impact of the sequelae of trauma on human wellbeing (Read *et al.,* 2001). There have been strong arguments that those experiencing the so-called positive "symptoms" of psychosis would be better categorised as having dissociative experiences and that psychosis itself would be better interpreted as stress-induced dissociation (Ellason *et al.,* 1996; Longden *et al.,* 2012; Moskowitz *et al.,* 2009; Ross, 2009). However, the precise way in which dissociation is involved in the relationship between trauma and psychosis remains somewhere unclear, not least because of the complexity of the mechanisms involved. Janet's original idea about the link between trauma and dissociation has been progressively supported by developmental research. The literature suggests that the disintegration in dissociation following trauma relates to the way different types of experiences are encoded in linguistic, somatic or affective forms (Schore, 2009). These forms map to specific cortical areas, leading to an enduring

predisposition towards chronic dissociation (Schore, 2009). Consequently, dissociative representations of trauma are associated with areas of the brain involved in emotional and sensory memory and regulation. Research suggests that this is typically driven by the right hemisphere (Lanius *et al.,* 2004; Metzger *et al.,* 2004).

The current review evaluates the evidence for the role of dissociation in the relationship between trauma and psychosis, including whether it has a mediating role. The review collects, summarises and critically appraises published research, which fits pre-specified inclusion criteria relevant to this question.

2. METHOD

2.1. IDENTIFICATION OF STUDIES AND STUDY SELECTION

A search strategy was established consistent with the Critical Appraisal Skills Programme guidance (CASP, 2014). The aims were to look for papers that most adequately addressed the question of interest, to include all important and relevant studies and to assess the quality of the included studies (CASP, 2014). Searches were conducted using databases selected on their relevance to the topic, namely: PubMed, PsychoInfo, Web of Science and Science Direct. Searches included the use of truncation symbols and wild card characters to retrieve studies with word variants which were variously combined using Boolean logic to generate a set of results related to the current question of interest (Cochrane Collaboration, 2011). Where new search terms were identified after initial searches, they were integrated into supplementary searches (Sampson & McGowan, 2006). There were three primary search strings: trauma, dissociation and psychosis (trauma OR traumatic OR trauma*, dissociation OR

depersonalis(z)ation OR derealis(z)ation and psychosis OR psychotic OR psychosis OR schizophren* OR severe mental OR serious psychotic OR serious mental OR high risk mental).

Following the initial identification of all articles through database searching, duplicates were removed and records were further screened. This was conducted using reference management software (www.mendeley.com). Full reports and studies were subsequently obtained and read to select eligible studies. In addition to searching electronic databases, studies were also located from visually scanning reference lists from relevant studies, hand-searching key journals, searching internet sources and using citation searching (Centre for Reviews and Dissemination, 2009). Stages of study selection was based on recommendations from the PRISMA Group (Shamseer *et al.,* 2015) and is displayed in a flow-chart format in figure 1. The purpose of an inclusion criteria (see table 1) was to ensure that the boundaries of the review question were clearly defined.

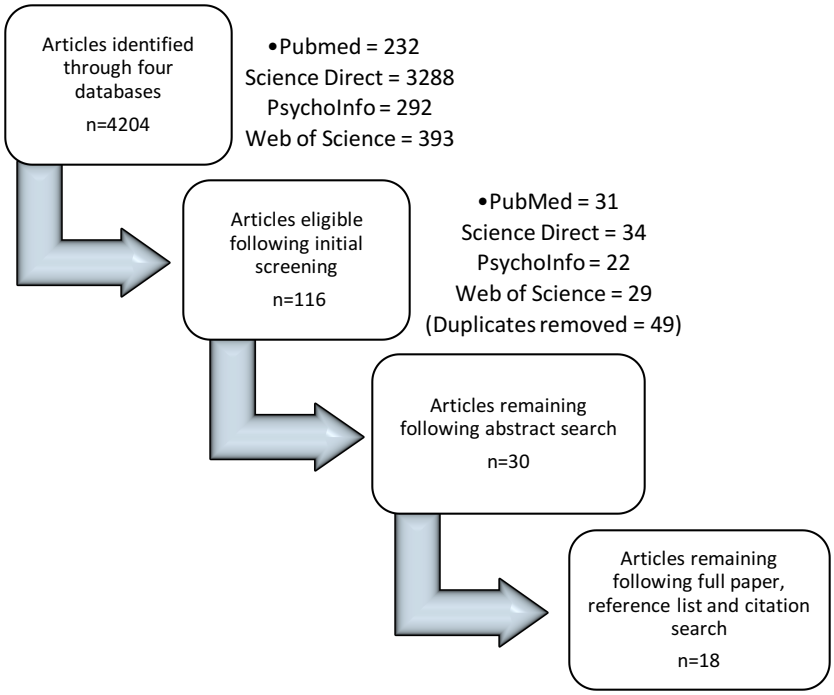

FIGURE 1 FLOW DIAGRAM OF SYSTEMATIC SEARCH

TABLE 1: INCLUSION CRITERIA APPLIED TO THE REVIEW

Inclusion Criteria	Exclusion Criteria
Empirical, peer reviewed studies with full-articles.	Abstracts, opinion papers, conference abstracts, reviews, book chapters, case studies/case reports were excluded from the review owing to the higher potential for bias in these study designs.
Written and published in the English language.	Any non-English language publications (due to time constraints, resources and facilities to appropriately translate) were excluded.
UK and non-UK-based studies (there were too few UK-based only).	Non-UK studies not written in English.
*Published between 1986 and 2016.	Anything published prior to 1986.
Based on an adult non-student population only.	Samples comprised of student-samples only were excluded due to their inability to contribute to clinical significance and other issues with bias (e.g. course points upon participation).
Included an assessment of dissociation* using a valid and reliable measure.	Measures which were not found to be valid or reliable.
Included an assessment of trauma history using a valid and reliable measure.	Measures which were not found to be valid or reliable.

*Although 1900 marks the period from which dissociation, trauma and psychosis were theorised as being intricately connected, the first valid measure of dissociation, the Dissociative Experiences Scale was not published until 1986.

2.2. DATA EXTRACTION

The Cochrane Collaboration's guidance on systematic reviews is not strictly applicable to the current research question because it generally relates to clinical trials, particularly randomised trials (Cochrane Collaboration, 2011) and it would involve *a priori study designs* where people would be exposed to the experience of trauma as an "intervention." The Cochrane Collaboration have a sub-committee, the Cochrane Non-Randomised Studies Methods Group (NRSMG) who have outlined methods for data extraction in non-randomised studies (Reeves *et al.,* 2008). The current review adhered to this Group's guidelines, in that non-randomised research studies for example were classified as "observational" even where the authors may have described them as cross-sectional or case-control. Data extraction primarily focused on general study information, study characteristics, participant characteristics and results (Centre for Reviews and Dissemination, 2009). Data was also gathered regarding how researchers controlled for selection bias, for example, whether they incorporated any design features such as matching, stratification or modelling. The aim of the data extraction process was to inform how the results may or may not have been influenced by the design or conduct of the study.

2.3. QUALITY ASSESSMENT

Quality assessment related to the extent to which the design, conduct, analysis and presentation of studies adequately answered the study's research question (Higgins *et al.,* 2003). Many of the most commonly accepted quality appraisal tools from the Cochrane Collaboration were not deemed appropriate to the current review as they are used mainly with respect to Randomised Controlled Trials. The NRSMG from the Cochrane Group (Reeves *et al.,* 2008) recommend examining the weaknesses of the designs that have been used and their potential to ascertain

causality, assessing their risk of bias, especially the potential for selection bias and confounding factors and considering the potential for reporting bias including selective reporting of outcomes. Therefore, in conjunction with the NRSMG's quality guidance, the quality measure from the Effective Public Health Practice Project Quality Assessment Tool for Quantitative Studies (EPHPP) was also used, as it is a tool which closely focuses on areas of bias and confounding variables, in keeping with the NRSMG's guidelines (Thomas, 2003). This rates sections as either strong, moderate or weak (where two weak ratings denote *weak*) with respect to: selection bias, study design, confounders, blinding, data collection methodology and withdrawals and dropouts. Table 2 presents the results of the overall EPHPP quality assessment ratings for each of the studies.

Areas of strength and weakness with respect to quality differed across the various studies. Most studies achieved a rating falling within the "weak" range (Alvarez *et al.,* 2015; Dorahy *et al.,* 2009; Perona-Garcelan *et al.,* 2010, 2012; Sar *et al.,* 2008; Schafer *et al.,* 2012; Thompson *et al.,* 2016; Varese *et al.,* 2012). A minority of studies achieved a rating falling within the "moderate" range (Braehler *et al.,* 2013; Schafer *et al.,* 2006; Schroeder *et al.,* 2016; Vogel *et al.,* 2011; Zincir *et al.,* 2014). None of the studies fell within the "strong" range. The studies with a weak rating were still included in the current review to determine the quality of the research in this area.

Within the studies areas of greatest quality related to the data collection method. This related to the inclusion criteria of only studies which used measures with good psychometric properties. Applicability or generalisability were often moderately rated also (referred to as "selection bias"). Areas of greatest weakness related to the blinding of studies, which was either not done or not reported, as was the reporting of withdrawals or drop-outs. As anticipated, the quality instrument, the EPHPP, was difficult to apply as non-randomised studies are

typically fraught with poorer methodological quality and are often missing important pieces of information, so that assessing methodological quality and risk of bias consistently across the studies proved to be particularly challenging (Reeves *et al.,* 2008). Methodological information in the current review was often quite difficult to find, often psychometric properties had to be found elsewhere, with original references to papers evaluating psychometric properties regularly not referenced. Often the conclusion was that various relevant pieces of information had not been reported which would have allowed the quality of the design and methodology to be evaluated more comprehensively.

2.4. DATA SYNTHESIS

Synthesis involved collating the results of the individual studies together and summarising their findings, consolidating the results using a narrative approach and exploring for inconsistencies. The synthesis began with constructing a brief descriptive summary of each of the respective studies in a table format including a brief overview of relevant findings, study characteristics and quality outcome (see table 3). The Centre for Reviews and Dissemination at the University of York (2009) advocates the use of four elements for a synthesis framework. Three out of four of these were relevant to the current question of interest which included: developing a primary synthesis of findings of included studies, exploring relationships within and between studies and assessing the robustness of the synthesis.

TABLE 2: QUALITY RATINGS BASED ON THE EPHPP AND NRSMG QUALITY ASSESSMENT STRATEGIES

Quality Rating (based on EPHPP and NRSMG quality assessment strategies)							
Author, date, country	**Selection bias**	**Study design**	**Confounders**	**Blinding**	**Data collection method**	**Withdrawals and dropouts**	**Global rating**
Alvarez *et al.* (2015) Spain	Moderate	Moderate	Moderate	Weak	Strong	Weak	Weak
Braehler *et al.* (2013) Canada	Moderate	Moderate	Moderate	Weak	Moderate	Strong	Moderate
Dorahy *et al.* (2009) Northern Ireland and Australia	Moderate	Moderate	Weak	Weak	Moderate	Strong	Weak
Evans *et al.* (2015) UK	Moderate	Moderate	Strong	Weak	Strong	Weak	Weak
Holowka *et al.* (2003) Canada	Moderate	Moderate	Weak	Weak	Weak	Weak	Weak
Kilcommons *et al.* (2005) UK	Weak	Moderate	Weak	Weak	Moderate	Weak	Weak
Laddis & Dell (2012) US	Moderate	Moderate	Weak	Weak	Strong	Weak	Weak
Laferriere-Simard *et al.* (2014) Canada	Moderate	Moderate	Moderate	Weak	Strong	Weak	Weak
Perona-Garcelan *et al.* (2012) Spain	Moderate	Moderate	Weak	Moderate	Strong	Weak	Weak

Author, date, country	Selection bias	Study design	Confounders	Blinding	Data collection method	Withdrawals and dropouts	Global rating
Perona-Garcelan *et al.* (2016) Spain	Moderate	Moderate	Weak	Weak	Moderate	Weak	Weak
Sar *et al.* (2008) Turkey	Moderate	Moderate	Weak	Weak	Strong	Strong	Weak
Schafer *et al.* (2006) Germany	Moderate	Moderate	Weak	Weak	Moderate	Strong	Weak
Schafer *et al.* (2012) Germany	Moderate	Moderate	Moderate	Weak	Strong	Strong	Moderate
Schroeder *et al.* 2016 Germany	Moderate	Moderate	Moderate	Weak	Strong	Moderate	Moderate
Thompson *et al.* (2016) Australia	Moderate	Moderate	Weak	Weak	Weak	Moderate	Weak
Varese *et al.* (2012) UK	Moderate	Moderate	Strong	Weak	Strong	Weak	Weak
Vogel *et al.* (2011) Germany	Moderate	Moderate	Moderate	Weak	Strong	Strong	Moderate
Zincir *et al.* (2014) Turkey	Moderate	Moderate	Moderate	Weak	Strong	Strong	Moderate

3. RESULTS

3.1. OVERALL SUMMARY OF STUDIES

Searches initially generated 4204 records. Following an initial screening of titles, keywords and abstracts, 116 articles were eligible for further attention. After abstracts had been read and duplicates had been removed, 30 articles remained. These articles were reviewed in relation to inclusion criteria. Of these, 18 were included to optimally address the current research question.

3.2. DEMOGRAPHIC CHARACTERISTICS

A total of 1,712 participants took part in the studies included in the review. The number of males to females reported was 888:714, with two studies not reporting information on gender and one study reporting that they had not recorded gender information for specifically two participants. The mean age was 35 with an age-range between 18-65. Three studies were undertaken in Spain, two in Turkey, three in Canada, four in Germany, one in Northern Ireland and Australia, one in Wales, two in England, one in Australia and one in the United States. Most studies (83%) did not report any information relating to ethnicity. Studies were recruited across a range of services, including two from mixed inpatient and outpatient, two from a specialist ward for psychotic disorders, three from a specialist ward for ultra-high-risk or service for early-intervention psychosis, three from a community mental health setting and five from either research training hospitals or university rehabilitation hospitals. The participants considered in the clinical studies were relatively diagnostically heterogeneous: “schizophrenia” (N=562), “schizoaffective disorder” (N=78), first-episode-psychosis (N=62), psychotic disorder not-otherwise-specified (N=14), affective psychosis (N=11), chronic psychosis (N=43),

"schizophreniform" (N=2), "dissociative identity disorder" (N=69), "mixed schizophrenia and schizophrenia spectrum disorder" (N=45), "mixed schizophrenia and schizoaffective disorder" (N=45), "other "schizophrenia spectrum disorders" (N=34), ultra-high-risk (N=311), "mixture of schizophrenia, schizoaffective disorder and brief psychosis" (N=50).

Some studies reported "controls" which, comprised "non-psychotic severe psychiatric" participants who had diagnoses of "depression", agoraphobia, "panic disorder", "social phobia", "panic and agoraphobia", "adjustment disorder" and "somatoform disorder". Other comparison groups were best defined as "non-clinical" (N=284). Two studies reported that gender was a confounding variable which had not been accounted for (Dorahy *et al.,* 2009; Laddis and Dell, 2012) and two studies incorporated gender and age into their model for analysis (Braehler *et al.,* 2013; Schroeder *et al.,* 2016). Only one study used approximate matching on their demographic variables (Evans *et al.,* 2015). The remainder of the studies reported that they had not found any significant differences for age and gender having tested for them statistically using t-tests or non-parametric tests without incorporating them into their model of analysis.

3.3. DESIGN/FEATURE CHARACTERISTICS

3.3.1. Summary

Only three studies were found to have used a specific form of mediation analysis to test the role for the association between trauma and psychosis. In the case of Thompson *et al.* (2016), they looked at the association with childhood sexual trauma only and used a Karlson Holm Breen model (Breen *et al.,* 2013) to decompose the effect of multiple variables, including dissociation on the pathway to an event. Varese *et al.* (2012) used a mediation analysis approach developed by

Imai *et al.* (2010a) to assess whether there was a mediating role for dissociation in the relationship between childhood trauma and hallucination-proneness. Perona-Garcelan *et al.* (2012) used a multiple mediation model. These studies were each classified as weaker in terms of quality rating.

Six studies used a form of regression analysis. Vogel *et al.* (2011) used stepwise forward binary regression, Laddis and Dell (2012) used regression analysis, Schroeder *et al.* (2016) used linear regression analysis and Sar *et al.* (2008) used step-wise linear regression as well as independent cluster analysis. Dorahy *et al.* (2009) used likelihood-ratio logistic regression analysis and Evans *et al.* (2015) used bootstrapping. Five studies used a form of correlational analysis, including Holowka *et al.* (2003), Kilcommons and Morrison (2005), Laferriere-Simard *et al.* (2014), Schafer *et al.* (2006) and Zincir *et al.* (2014). Braehler *et al.* (2013) used a mixture of correlational analysis and multi-variate analysis. Alvarez *et al.* (2015) and Perona-Garcelan *et al.* (2010) used non-parametric analysis and Schafer *et al.* (2012) used analysis of variance. All but Vogel *et al.* (2011), Schafer *et al.* (2006), Schroeder *et al.* (2016) and Zincir *et al.* (2014) had a lower quality rating.

3.3.2. Commentary

Methods of analysis varied across the studies. Where a specific mediation approach was not used, it was often challenging to establish if and how they had tested a mediating relationship for dissociation between trauma and psychosis. Within the so-called hierarchy of evidence, the research designs within the current review represent a lower level of evidence and a lower quality of study. However, the nature of the research question precludes the use of certain alternative, higher-level investigative approaches. Understandably, the potential for biases is much greater in non-randomised studies compared to randomised trails (Reeves *et al.* 2008). The extent of the methodological diversity meant that it was

challenging to account or control for biases in the analysis of the studies, design and methodology. Any results from the current review must therefore be interpreted with caution. There was a great deal of heterogeneity in the studies and the generally small sample sizes, combined with a lack of reporting of power analysis, narrowed the extent to which the observations can ever be generalised. Given how so many studies used "cross-sectional" and correlational design, it is difficult also to determine any causal relationship. It poses the question as to whether correlational or regression methodologies are too limited in scope to answer the current research question. Other approaches, such as longitudinal studies might better track any causal relationship between trauma, dissociation and psychosis.

3.4. Measures

Details regarding research measures employed in the included studies are displayed in Table 3.

3.4.1. Measuring trauma

3.4.1.1. Summary

There was some variation in how trauma was assessed and the reporting of the measures, with all but one study using measures with moderate to strong psychometric properties. Two-thirds of the studies (66%) included the Childhood Trauma Questionnaire (CTQ) (Bernstein & Fink, 1998). The remaining studies used six different measures of trauma. One study (Alvarez *et al.,* 2015) used the short form version of the CTQ and Thompson *et al.* (2016) used the brief version. The CTQ has been found to have moderate to strong psychometric properties

(Bernstein & Fink, 1998; Scher *et al.*, 2001). Kilcommons and Morrison (2005) included the Trauma History Questionnaire (THQ) which has strong psychometric properties (Green, 1996). Perona-Garcelan (2012) used the Trauma Questionnaire (TQ) translating it into Spanish. They did not cite any psychometric properties for their Spanish translated version which contributed to their weaker quality rating. Laddis and Dell (2012) used the Traumatic Experiences Questionnaire (TEQ) which has been found to have good psychometric properties (Nijenhuis *et al.,* 2012). Schroeder *et al.,* (2016) used the Structured Trauma Interview (STI) (Draijer, 1989). Vogel *et al.* (2011) used the German version of the Post-Traumatic Distress Scale (PDS) which has good psychometric properties (Ehlers *et al.,* 1996; Foa *et al.,* 1993).

3.4.1.2. Commentary

Trauma is a complex phenomenon and can be characterised in many ways, especially at the item level. There may have been variation in how participants themselves would have described their experiences. One study (Dorahy *et al.,* 2009) used the additional section of the CTQ to measure the impact of the trauma. The other studies did not appear to measure the subjective *impact* of the trauma with the two studies who used the Trauma Questionnaire (Perona-Garcelan *et al.,* 2010; 2012) explicitly stating that they eliminated items on the scale valuing impact. The CTQ, used by 66% of studies asks respondents to say whether each statement was true during their childhood with regards to the following categories: emotional abuse and neglect, physical abuse and neglect, denial, sexual abuse. The TEQ looks at similar traumatic experiences, with the addition of sexual harassment and bodily threat from another. The STI also adds being a witness to domestic violence, early loss and parental dysfunction and assesses physical abuse and sexual abuse after the age of 16. The CATS looks at the perceived severity of maltreatment during childhood in addition to the subscales

of similar subscales to the CTQ. The THQ adds disaster, loss and combat both before and after age 16. The TQ looks at whether certain traumatic events were ever experienced including: accidents, loss, threat, unexpected death, witnessing injury or violence, near drowning, physical abuse, being burned, held captive, military combat, assault, sexual assault, kidnap and childhood sexual abuse and the age at which these occurred. The trauma measures used did not assess symptoms of trauma currently, their utility appeared to be about the exposure to trauma and frequency at which this occurred historically, particularly during childhood. Apart from the Structured Trauma Interview used by Schroeder *et al.* (2016) the measures of trauma were all self-report. Although accounts of trauma have been found to be reliable (Bifulco *et al.,* 2002; Read *et al.,* 2003) self-report may have been affected by numerous factors, including infantile amnesia, interpretation biases, traumatic amnesia, source confusion, unawareness or repression. Each of these or a combination of these could have significantly invalidated self-report (Colangelo, 2009; Feldman-Summers & Pope, 1994; Freyd *et al.,* 2001; Geraerts & McNally, 2008).

3.4.2. Measuring dissociation

3.4.2.1. Summary

Most studies (83.3%) used the Dissociative Experiences Scale (Bernstein & Putnam, 1986) with three using the German-version. Four studies used the Dissociative Experiences Scale - II and one study used the DES-Taxon (DES-T) which is an eight-item version of the full 28-item DES. Both the DES and DES-T have good psychometric properties (Bernstein & Putnam, 1986; Dubester & Braun, 1995; van Ljzendoorn & Schuengel, 1996).

Of those who did not use the DES, Laddis and Dell (2012) used the Multidimensional Inventory of Dissociation (MID) which has fourteen, 12-item dissociation scales (Dell, 2006a). Dorahy *et al.* (2009) used the Dissociative Disorders Interview Schedule (DDIS) in conjunction with the DES-T which is a structured interview schedule which works in tandem with DSM-5 to make diagnoses, including dissociative disorders. Two studies (Thompson *et al.,* 2016 and Vogel *et al.,* 2011) used other alternative measures of dissociation, the Comprehensive Assessment of At-Risk Mental States (CAARMS) and the Arbeitsgemeinschaft Methodik und Dokumentation in der Psychiatrie –Dis (AMDP-dis). The use of CAARMS fitted with Thompson's *et al.* (2016) use of an ultra-high-risk population (Yung *et al.,* 2005). The CAARMS has good psychometric properties (Yung *et al.,* 2005). Vogel *et al.* (2011) used the German version of the AMDP-dis (Freyberger & Moller, 2004).

3.4.2.2. Commentary

Most studies used a measure (the DES) which focuses on amnesic dissociation, absorption, imaginative involvement, depersonalisation and derealisation. Alternatives, such as the MID and DDIS have been found to have good psychometric properties. It is also comparable with the DES (Ross *et al.,* 2002; Steinberg, 1995). Only two out of the 18 studies used alternative measures which do not have any literature on how well they converge with or correlate with the DES or MID.

Both the MID and the DES show some evidence of trait stability - the DES has a one-year temporal stability of .78 (Putman *et al.,* 1992) and the MID has a four to eight-week temporal stability of .97 (Somer & Dell, 2005). Both the DES and MID dissociation scores have been found to correlate strongly with the Trauma Experiences Questionnaire scale scores (Dell, 2006a). In one study, Dell (2006a)

found that the most powerful predictor of overall traumatisation scores was a severe dissociation score, which accounted for 18% of the variance compared to the DES. Although most studies used the DES, one disadvantage of this measure worth considering is that it includes a mixture of both pathological and "normal" dissociation, regarded by some as over-inclusive (Dell, 2009; Laddis & Dell, 2012; Van der Hart *et al.,* 2004). The alternative, MID, more sensitively measures the association between trauma and pathological dissociation.

3.4.3. MEASURING PSYCHOSIS

3.4.3.1. Summary

Many of the studies used multiple ways to measure psychosis. Fifty percent of the studies started with using the Positive and Negative Symptom Scale (PANSS) (Evans *et al.,* 2015; Kilcommons *et al.,* 2005; Perona-Garcelan *et al.,* 2010, 2012; Schafter *et al.,* 2006, 2012; Schroeder *et al.,* 2016; Varese *et al.,* 2012 and Zincir *et al.,* 2014). The PANSS has been shown to have good psychometric properties. Two of the studies used the Scale for the Assessment of Positive Symptoms (SAPS) and Scale for the Assessment of Negative Symptoms (SANS) (Sar *et al.,* 2008 and Vogel *et al.,* 2011). The PANSS has high concurrent validity in relation to the SAPS and SANS (Kay *et al.,* 1988; Peralta & Cuesta, 1994).

Thirty-eight percent of the studies used a form of the Structured Clinical Interview for DSM (SCID) (Braehler *et al.,* 2013; Holowka *et al.,* 2003; Laddis & Dell, 2012; Lafferriere-Simard *et al*., 2014; Sar *et al.,* 2008; Schafer *et al.,* 2012; Schroeder *et al.,* 2016) which is a semi-structured interview towards making DSM-Axis I diagnoses (see table 3). The SCID-II, which is used for making DSM-IV Axis II personality disorder diagnoses was used by two of the studies (Lafferriere-Simard *et al.,* 2014; Sar *et al.,* 2008). Three studies used a version of the DSM (Alvarez *et*

al., 2015; Dorahy *et al.,* 2009; Holowka *et al.,* 2003; Perona-Garcelan *et al.,* 2010). Three further studies also used the Mini International Neuropsychiatric Interview (MINI) (Schafer *et al.,* 2006; Schafer *et al.,* 2012; Schroeder *et al.,* 2016). Only one study used quite different measures which included the Comprehensive Assessment of at Risk Mental State, Brief Psychiatric Rating Scale (BPRS) and Comprehensive Assessment of Symptoms and History (CAARMS) (Thompson *et al.,* 2016).

3.4.3.2. Commentary

All the studies looked to conventional approaches to clarifying the "diagnoses" of their participants. Surprisingly, none of the studies used the SCID-I-Revised Version which is the standard form designed for use in research. Issues regarding the SAPS and SANS have been raised by Minas *et al.* (1992) who suggest that the SAPS and SANS became a popular measure before its psychometric properties had been evaluated thoroughly. This could be extended to the PANSS also. In attempting to elucidate the role of any relationship between trauma, dissociation and psychosis, researchers seem to gravitate towards grouping people by a diagnostic label and from there tracking through a potential etiological trajectory, with all its complexity. In doing so, the very process of dividing out and "measuring" different things, complicates attempts to draw robust conclusions from the current review.

3.6. THE RELATIONSHIP BETWEEN TRAUMA, DISSOCIATION AND PSYCHOSIS

Fourteen studies (77%) observed a relationship between trauma and dissociative symptoms in their samples of participants with psychosis. Several of these studies highlighted the role of severity and type of trauma experienced. Braehler *et al.*

(2013) and Holowka *et al.* (2003) observed that the more chronically psychotic patients had the most severe dissociative symptoms and that *severity* of childhood trauma was associated with more severe dissociative symptoms, with emotional abuse the most important indicator of dissociation in psychotic patients. Alvarez *et al.* (2015) observed a relationship between emotional, physical and sexual abuse and the magnitude of dissociation in their schizophrenia sample. Where patients had experienced four or five types of trauma, their level of dissociation was markedly higher, described as polytraumatisation.

The pronounced relationship between emotional abuse and dissociative symptoms observed by Braehler *et al.* (2013) and Holowka *et al.* (2003) was replicated by Schafer *et al.* (2006). Schafer *et al.* (2012) observed that emotional abuse was most strongly associated with dissociative symptoms which extended their previous study (Schafer *et al.,* 2006) where the biggest association was with both emotional and physical neglect. Evans *et al.* (2015) observed there was a positive mediating relationship between physical neglect, dissociation and psychosis. Sar *et al.* (2008) found that young age, childhood physical abuse and neglect predicted dissociation, though this did not correlate with psychosis. Schroeder *et al.* (2016) observed a significant association between aspects of dissociation and trauma including childhood sexual abuse, being a witness of domestic violence, paternal dysfunction and violence in adulthood. These studies were weak to moderate in terms of quality rating.

A sub-set of the studies focused specifically on hallucinations or delusions, with findings particularly related to sexual abuse, violence and hallucinations. Kilcommons and Morrison (2005), observed that depersonalisation (as a sub-component of dissociation) predicted hallucinations regardless of how severe the traumatic experience had been which had been indicated already by Perona-Garcelan *et al.* (2010, 2012). In both a control and psychosis sample combined,

they also found that dissociation mediated the relationship between neglect or a negative home environment and hallucination-proneness which reinforces the idea that this *type* of traumatic experience may play an important role. Dorahy *et al.* (2009), who looked at voice-hearing only, observed that the combination of maltreatment and dissociation increased the likelihood of voice-hearing before adulthood. Varese *et al.* (2012) observed that the relationship between trauma and hallucination-proneness was positively mediated by dissociation, particularly with respect to sexual abuse. Perona-Garcelan *et al.* (2012) observed that specifically depersonalisation acted as a mediator between trauma and hallucinations/delusions. These studies were classified as being weaker in quality ratings.

The studies included in the current review suggest overall that distinct types of childhood trauma may be more related to dissociation in participants who have experience of psychosis. These include emotional abuse, exposure to violence, sexual abuse, physical neglect and physical abuse. Arguably, these studies highlight how experiences which may be less researched (i.e. abusive/traumatic experiences other than sexual or physical abuse) may have an important role in dissociation.

There were exceptions, with the findings of four studies contrasting with the others. Three out of four of these studies were classified as being weaker in quality (Laddis & Dell, 2012; Lafferriere-Simard *et al.,* 2014; Thompson *et al.,* 2016). Laferriere-Simard *et al.* (2014) found that in the first instance, in their sample, childhood trauma and dissociation were not even related. This was an unexpected finding given that they had anticipated replicating the other studies which reported a link between childhood trauma and dissociation. They attributed their findings to possible artifacts in the measurement instruments. Laddis and Dell (2012) found no relationship either between dissociation and childhood trauma

scores. Zincir *et al.* (2014) had compared a group with affective "disorders" to those with psychotic "disorders" and did not find that there was a significant difference between the two groups on reports of dissociation or traumatic experiences. They also found no relationship between positive symptoms and childhood trauma or dissociation. Thompson *et al.* (2016) found no mediating role for dissociation with regards to sexual trauma and transition to psychosis.

Table 3 Summary of studies (acronyms on following page)

	Based on NRSMG				**Measures**			
Author, date, country of recruitment	Description of study design	Sample Type/Dx	Total N	Group N's	Trauma	Dissociation	Psychosis	Main relevant findings
Alvarez *et al.* (2015) Spain	Observational	Clinical + Non-Clinical	123	78 = HC's 45 = SZ/SZAff	CTQ-SF	DES-II	DSM-IV	Association between trauma and intensity of dissociation. Emotional, physical and sexual abuse most associated. Dissociation increased with poly-traumatisation.

Author, date, country of recruitment	Description of study design	Sample Type/Dx	Total N	Group N's	Trauma	Dissociation	Psychosis	Main relevant findings
Braehler *et al.* (2013) Canada	Observational	FEP Chronic Psychosis	171	62 = FEP 26 = SZ 14 = PDNOS 11 = Affec/Psych 43 = CPychotic 66 = NCC's	CTQ	DES	SCID	Participants described as chronic had the most severe dissociative symptoms, followed by FEP, followed by NCC's. The more severe the childhood trauma, the more severe the dissociative symptoms, particularly for emotional abuse.
Evans *et al.* (2015) UK	Observational	First episode psychosis + Non-clinical	60	29=Clinical 31=Non-clinical	CTQ	DES-II	PANSS	Dissociation positively mediated the relationship between physical neglect and psychosis.

Author, date, country of recruitment	Description of study design	Sample Type/Dx	Total N	Group N's	Trauma	Dissociation	Psychosis	Main relevant findings
Holowka *et al.* (2003) Canada	Observational	SZ	26	26 = SZ	CTQ	DES	SCID for DSM-III-R	Forms of maltreatment were correlated with dissociative symptoms in SZ patients.
Kilcommons *et al.* (2005) UK	Observational	SZ Spectrum Disorders	32	16 =SZ 16 = otherSSD	THQ	DES	PANSS	Association observed between psychotic experiences and dissociation, particularly depersonalisation and hallucinations.
Laddis and Dell (2012) US	Observational	DID SZ	80	40 = SZ 40 = DID	TEQ	MID	SCID-Axis 1 for DSM-IV (psychotic disorders module only)	Dissociation scores of SZ patients were unrelated to their reports of childhood maltreatment.

Author, date, country of recruitment	Description of study design	Sample Type/Dx	Total N	Group N's	Trauma	Dissociation	Psychosis	Main relevant findings
Laferriere-Simard *et al.* (2014) Canada	Observational	Psychotic Disorders	50	Mix of: SZ SZ/iform SZ/Aff BPD But does not give breakdown	CTQ	DES	SCID-I SCID-II SCID-D	Total scores for dissociation and childhood trauma were not associated.
Perona-Garcelan *et al.* (2012) Spain	Observational	Psychosis	71	66=Par/SZ 3=SZ/Aff 1= Del/Dis	TQ	The DES-II	PANSS	Childhood traumas positively correlated with dissociation and features of psychosis. Dissociation as a mediating factor.

Author, date, country of recruitment	Description of study design	Sample Type/Dx	Total N	Group N's	Trauma	Dissociation	Psychosis	Main relevant findings
Perona-Garcelan *et al.* (2016) Spain	Observational	Psychoses	37	34 = SZ Disorder 3 = SZ/Aff	TQ (Spanish trans)	DES-II	DSM-IV PANSS	Childhood traumas led to higher dissociation compared to traumas experienced during adulthood in hallucinations.
Sar *et al.* (2008) Turkey	Observational	SZ Disorder	70	70 = SZ Disorder	CTQ	DES (Turkish version) DDIS	SCID-II (for DSM-IV) SAPS and SANS	Observed a dissociative "sub-group" among the SZ participants. Experiences of childhood trauma related to concurrent dissociation.
Schafer *et al.* (2006) Germany	Observational	Psychosis/ SSD	30	20 = SZ 2 = SZ/form 8 = SZ/Aff	CTQ	DES (German version)	MINI DSM-IV (psychosis section) PANSS	Emotional and physical neglect showed the most pronounced relationships with dissociative symptoms. Correlation between dissociative symptoms and abuse no longer significant following stabilisation.

Author, date, country of recruitment	Description of study design	Sample Type/Dx	Total N	Group N's	Trauma	Dissociation	Psychosis	Main relevant findings
Schafer *et al.* (2012) Germany	Observational	Psychotic Disorders	145	104 = SZ 32 = SZ/Aff 9 = otherSSD	CTQ	DES (German version)	PANSS MINI SCID-IV	Dissociative symptoms in patients with SZ are state-dependent. Childhood sexual abuse was the best predictor of dissociative symptoms.
Schroeder *et al.* 2016 Germany	Observational	Psychotic Disorders	145	145 = SSD	STI	DES (German version)	MINI SCID-IV (psychosis section) PANSS (NEG AND POS)	Specific association amongst psychosis patients who reported sexual abuse/paternal dysfunction in childhood.
Thompson *et al.* (2016) Australia	Observational	Ultra-high-risk population	311	311 = UHR	Brief CTQ	CAARMS	CAARMS BPRS CASH	No significant mediation between sexual trauma and transition to psychosis mediated by dissociation.
Varese *et al.* (2012) UK	Observational	SZ Spectrum Disorders	45	45=SZ/SSD 20 = HC's	CATS	DES	PANSS SCI-PANSS	Mediating role of dissociative tendencies, childhood trauma and hallucination proneness.

							LSHS-R (hallucination proneness only)	Particularly relates to sexual abuse.
Author, date, country of recruitment	Description of study design	Sample Type/Dx	Total N	Group N's	Trauma	Dissociation	Psychosis	Main relevant findings
Vogel *et al.* (2011) Germany	Observational	Par/SZ Varied Dx	60	35 = Non psychotic disorder 25 = Par/SZ	CTQ PDS	AMDP-Dis	SAPS and SANS	Link between negative symptoms and childhood traumas, more relevant for "chronic" psychosis. Presence of any childhood trauma positively correlated with negative symptoms in patients with SZ.
Zincir *et al.* (2014) Turkey	Observational	Psychotic Disorders NPSPD	78	54 = SZ NPSPD = 24	CTQ-28	DES	SCID-I PANSS SCL-90-R	No correlation between psychosis and dissociation. Dissociation linked to greater levels of delusions and hallucinations.

Aff/Psych = Affective Psychosis

AMDP = Arbeitsgemeinschaft Methodik und Dokumentation in der Psychiatrie (Freyberger & Moller, 2004)

BCTQ = Brief Childhood Trauma Questionnaire (Bernstein & Fink, 1998)

BBTS = Brief Betrayal Trauma Survey (Goldberg & Freyd, 2006)

BPD = Brief Psychotic Disorder

BPRS = Brief Psychiatric Rating Scale (Overall & Gorham, 1962; Lukoff *et al.,* 1986)

CAARMS = Comprehensive Assessment of At-Risk Mental States (Yung *et al.,* 2005)

CASH = Comprehensive Assessment of Symptoms and History (Andreasen, 1987)

CATS = Child Abuse and Trauma Scale (Sanders & Becker-Launsen, 1995)

C Psychotic = Chronic Psychotic

CTQ = Childhood Trauma Questionnaire (Bernstein & Fink, 1998)

CTQ-SF = Childhood Trauma Questionnaire Short Form (Bernstein & Fink, 1998; Bernstein *et al.,* 2003)

DDIS = Dissociative Disorders Interview Schedule (Ross *et al.,* 1989)

Del/Dis = Delusional Disorder

DES-II = Dissociative Experiences Scale (Carlson & Putnam, 1993)

DES-T = Dissociative Experiences Scale – Taxon (Waller *et al.,* 1996)

DID = Dissociative Identity Disorder

DSM-IV = Diagnostic and Statistical Manual of Mental Disorders Fourth Version (American Psychiatric Association, 1994)

Dx = Diagnosis

FEP = First Episode Psychosis

HC's = Healthy Controls

LEC = Life Events Checklist

Other SSD = Other Schizophrenia Spectrum Disorders

PANSS = Positive and Negative Syndrome Scale (Kay *et al.,* 1987)

Par/SZ = Paranoid Schizophrenia

PDS = Post-Traumatic Distress Scale (Foa *et al.,* 1993)

PQ = Prodromal Questionnaire (Loewy *et al.,* 2005)

PSNOS = Psychotic Disorder Not Otherwise Specified

SAPS and SANS = Scale for the Assessment of Positive Symptoms and Scale for the Assessment of Negative Symptoms (Andreasen & Arndt, 1995)

SCL-90-R = Symptom Checklist 90 Revised (Derogatis, 1986)

STI = Structured Trauma Interview

TEQ = Traumatic Experiences Questionnaire (Nijenhuis *et al.,* 2002)

TDS = Traumatic Dissociation Scale

THQ = Trauma History Questionnaire (Green, 1996)

TQ = Trauma Questionnaire (Davidson *et al.,* 1990)

SZ/Aff = Schizoaffective Disorder

SCI-PANSS = Structured Clinical Interview for the Positive and Negative Syndromes Scales

SHUT-D = Shutdown Dissociation Scale

SZ = Schizophrenia

SSD = SZ Spectrum Disorders

SCID-IV = Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (First *et al.,* 1996)

SCID-I = Structured Clinical Interview for DSM-IV Axis I (First *et al.,* 1996)

SCID-II – Structured Clinical Interview for DSM-IV Axis II

SCID-D = Structured Clinical Interview for DSM-IV Dissociative Disorders (Steinberg *et al.,* 1990)

LSHS-R = Launay-Slade Hallucination Scale – R (Bentall & Slade, 1985)

MACE = Maltreatment and Abuse Chronology of Exposure

MID = Multidimensional Inventory of Dissociation (Dell, 2006a)

MINI = Mini International Neuropsychiatric Interview

MOPS= Measure of Parenting Style

MUPS = Mental Health Research Institute Unusual Perceptions Schedule (Carter *et al.,* 1995)

NCC = Non-Clinical Controls

NPSPD = Non-psychotic severe psychiatric disorders

STI = Structured Trauma Interview (Draijer, 1989)

SZ/iform = Schizophreniform

TQ = Trauma Questionnaire (Davidson *et al.,* 1990)

TDS = Traumatic Dissociation Scale

4. Discussion

The aim of the current review was to systematically evaluate the quality of the evidence regarding the role of dissociation in the relationship between trauma and psychosis. The literature search identified 18 articles that met the inclusion criteria. Three-quarters of the studies found that certain types of traumatic experiences are associated with dissociation in samples comprised of people with various types of psychosis-related experiences. Severity of childhood trauma, cumulative traumatic experiences and type of traumatic experience stood out as being particularly relevant to the role of dissociation within psychosis.

Only a minority (16%) of studies were designed to look specifically at a mediating role for dissociation in the relationship between trauma and psychosis. These studies were rated as having a weaker quality rating. The remaining studies used either a variant on regression, non-parametric or correlational analysis, with again, most having a weaker quality rating. This of course means that it is difficult to make anything but conservative estimates of how specifically dissociation may have a mediating role between trauma and psychosis. Although there is accumulating evidence for the association between childhood trauma and psychosis, underlying mechanisms are poorly understood and it remains difficult to draw any robust conclusions from the current review about whether this association really is mediated by dissociation and how this might be happening but, at a minimum, there is some evidence that childhood trauma and subsequent dissociation may be influencing the pathway to psychosis.

One possibility is that dissociation may result from fragmentation affecting the medial-temporal-lobe and hippocampus (Bob, 2011). Nadel and Jacob (1998) claim that when the hippocampus's critical importance to the aggregation of

memory becomes disrupted, there may be a lack of spatio-temporal context to accompany strong emotional memories. Later strong affective experiences may be evoked when an early memory is triggered without conscious recollection of the trauma.

The current review corresponds with the literature on the association between traumatic experiences early in life and the development of psychosis. What stands out from the current review is the relevance of the *type, frequency* and the *amount* of abuse experienced, particularly in childhood, broadening the spectrum of early suffering beyond just sexual and physical abuse. There were pronounced relationships between emotional abuse, emotional neglect (Alvarez *et al.,* 2015; Braehler *et al.,* 2013; Holowka *et al.,* 2003; Schafer *et al.,* 2006, 2012), physical neglect (Alvarez *et al.,* 2015; Evans *et al.,* 2015; Sar *et al.,* 2010), exposure to violence (Schroeder *et al.,* 2016), childhood sexual abuse (Alvarez *et al.,* 2015; Schafer *et al.,* 2012; Schroeder *et al.,* 2016) and dissociation. These studies had weaker quality ratings except for Braehler *et al.* (2013), Schafer *et al.* (2006) and Schroeder *et al.* (2016) who had moderate quality ratings. Nonetheless, these findings indicate that there may be lasting damaging effects from distinct types of abuse which conveys an enduring psychological vulnerability and suggests that perhaps certain early experiences of trauma may leave one more vulnerable to cumulative traumatic experiences later. Alvarez *et al.* (2015), in their study, observed that those who had experienced four or five types of trauma had a Dissociative Experiences Scale score of 27.27 which is nine points higher than the average score in their clinical sample. Not unsurprisingly, those classified as the most chronic in terms of duration and severity of psychosis had more severe levels of dissociation (Braehler *et al.,* 2013). Sar *et al.* (2008) even identified a dissociative-subtype in their psychosis sample. This converges with those who theorise that unhealthy dissociation which leads to pathology is associated with

greater fragmentation in the face of traumatic experiences (Dixon, 1998; Mollon, 1996; Putman, 1997; van der Hart *et al.,* 2006).

The findings from the current review, as anticipated, also converge with the literature linking childhood sexual abuse and hallucinations (Read & Argyle, 2000; Ross *et al.,* 1994) with evidence that dissociation is more so associated with the formation of auditory hallucinations than delusional ideas. Again, exactly *how* this happens cannot be explained by the studies included in the current review and one important question that the current review raises is exactly which underlying mechanisms relate to dissociation following trauma in the pathway to psychosis. A systemic review of the literature undertaken previously looks at the relationship between dissociation and voices specifically (Pilton *et al.,* 2015). The review undertaken by Pilton *et al.* (2015) includes five of the studies included in the current review (Dorahy *et al.,* 2009; Kilcommons and Morrison, 2005; Perona-Garcelan *et al.,* 2010, 2012; Varese *et al.,* 2012). These studies focused specifically on hallucinations and found that dissociation was associated with various aspects of maltreatment. Two of the studies from Pilton *et al.* (2015) included in the current review reiterated the role of *depersonalisation* following the traumatic experience of being sexually abused, leading to hallucinations when accompanied by dissociation (Kilcommons & Morrison, 2005; Perona-Garcelan *et al.,* 2012). Depersonalisation relates to the feeling of being removed from oneself, as if an external observer of one's own mind or body (Berrios & Sierra, 1997). A hypothesised dissociative model would consider auditory hallucinations as either disowned experiences or emotional representations related to traumatic experiences (Corstens *et al.,* 2011, 2013).

4.1. Limitations of the current review

There are several limitations to the current review which restrict the conclusions that can be made, some of which have already been alluded through throughout.

These include the constraints imposed by the inclusion criteria, which may have resulted in potentially important information being omitted (e.g. single case-study designs). The qualitative tool used in the current review may have been influenced by subjectivity and was not strengthened by a second rater. In terms of quality, over 77% of studies were classified as weak with several design issues identified which meant that it was difficult to compare across studies and it was often challenging to control for or account for biases in the analyses. Finally, several studies were from outside the UK, with little detail about ethnic backgrounds of the participants, which also makes it difficult to cross-compare from one country to another. The results of the current review would of course benefit from being supplemented by other sources of evidence perhaps including longitudinal research, which was noticeably absent, and more comprehensive assessment of dissociation. Similar limitations were highlighted by Pilton *et al.* (2015) who looked at some of the same kinds of studies and recommended that conclusions from their review were drawn with care.

A methodological issue that is worthy of attention with respect to the current review is the overlap between the various diagnoses as it may have skewed the results (Foote & Park, 2008). The very way in which the taxonomic model permeates clinical practice means that research participants are inevitably categorised and compared based on their diagnoses. As outlined by Ross (2009), features of dissociative psychosis also prevail in other diagnostic categories including “depression”, post-traumatic- stress disorder, “borderline personality disorder”, “obsessive compulsive disorder”, “panic disorder” and substance misuse. In the current review, even the so-called “control groups” often fitted these descriptions. The studies included in the current review would undoubtedly have also been impacted by the overlap between schizophrenia and the features of dissociative identity disorder; 25-40% of individuals in treatment for schizophrenia report dissociation and would have met the DSM-IV-TR criteria for

complex dissociative disorders (Ross *et al.,* 1989) and both schizophrenia and dissociative-identity-disorder include auditory hallucinations (Foote & Park, 2008). The measures used by the studies in the current review of dissociation simply cannot distinguish between the classical dissociation of "Dissociative-Identity-Disorder" and what are suspected as being dissociation-*like* phenomena occurring in psychosis (Laddis & Dell, 2012).

4.3. Concluding remarks

The current review contributes to the emerging literature on the re-conceptualisation of psychosis which emphasises the importance of the life experiences of the individual and their legacy (Read, 2013). Although the current review cannot provide direct evidence, further exploration of dissociative processes may be meaningful for highlighting how certain traumatic experiences may contribute to psychosis. A common issue is that measures of dissociation only inform us about phenomenology, not actual etiology. Consequently, it is quite difficult to make sense of underlying mechanisms and it remains to be established precisely by which mechanism(s) aspects of psychosis are produced and if various risk factors are affected mechanistically in the same way (Bentall *et al.,* 2014). It would be premature to expect a subtype of dissociative psychosis to be established, but the current review, in the very least, supports the view that strict a delineation between the psychoses, dissociative disorders and traumatic disorders are overly simplistic.

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PART II RESEARCH REPORT

Critical thinking and psychiatric knowledge:
how psychiatrists understand and engage with
psychosis as a contested area

ABSTRACT

INTRODUCTION In 2014, The British Psychological Society and Division of Clinical Psychology published a report: "*Understanding Psychosis and Schizophrenia.*" Key aspects of the report were that there are *alternative ways* of thinking about psychosis or "schizophrenia," that each viewpoint has its advantages and disadvantages and that psychosis is a contested area. The Critical Psychiatry Network is an organisation also involved in highlighting different areas of contention in psychosis. This report sits within the context of psychiatry's history and dominant ideas related to bio-reductionism.

METHOD Semi-structured interviews were conducted with 12 psychiatrists at both trainee and qualified level across three NHS Trusts. The sample was representative of different perspectives. Critical Narrative Analysis, an approach developed by Darren Langdridge, comprised of six stages was used. This approach involves a critique of the self, a narrative analysis of each interview, attending to rhetorical function and tone and a critique using a hermeneutic of suspicion. The research was informed by a dialogical-contextual-constructionist epistemology.

RESULTS Three groups of psychiatrists were in evidence – a group of biological psychiatrists, critical psychiatrists and those more conflicted. Narrative analysis was undertaken for each participant. Following this, five themes emerged – conventional orthodoxy, invulnerability and expectation, power, disempowerment and populism, dampening creativity and space for reflection. There was a total of 14 corresponding sub-themes. The results were discussed with respect to their relevance to the literature and implications for practice including the significance of power, the role of dialogue and the presence of reflexivity.

CONCLUSION The research highlighted the divergent opportunities within the psychiatric profession to hear alternative views. Such opportunities could lead to wider learning and understanding of ways to engage with psychosis, particularly as it remains an area of great contention.

INTRODUCTION

In 2014, the British Psychological Society (BPS) and the Division of Clinical Psychology (DCP) published an update of a report originally published in 2000 called "*Understanding Psychosis and Schizophrenia.*" The report related to both the understanding of psychosis and what can be done to help. The authors stated that psychosis was previously thought of as being a largely biological illness. They explained that they were seeking to broaden this out by drawing more attention to psychological and social factors associated with the experience of psychosis. A key aspect of the report was that the contributors promoted the idea that there are *alternative ways* of thinking about psychosis or "schizophrenia", and that each viewpoint has its advantages and disadvantages. Their stance was that there is neither a clear-cut explanation for the etiology of psychosis or "schizophrenia", nor is there a robust consensus about what helps people the most. They strongly advocated for a position that is open to understanding psychosis from different perspectives.

The conceptualisation of psychosis is often influenced by beliefs around etiology. Some hold the view that psychosis is largely biological in origin, diagnosable and attributable to imbalances in mechanistic pathways. This conceptualisation has its origins in the Kraepelin classification system. Kraepelin's vision was that each diagnosis would eventually become correspondent to specific etiological pathways. This view has held strong partly because of evidence from gene association and family pedigree studies amongst those who hope to map molecular etiology onto diagnosis in the belief that it will improve patient care (Corvin & Sullivan, 2016; Craddock & Owen, 2014; Lichstenetin *et al*., 2009; O' Donovan *et al.,* 2008; Mulle, 2012; Straub & Weinberger, 2006). Others argue that the diagnostic classification system lacks validity and is undesirable (Bentall, 2010). Bentall would argue that the drive to see psychosis as a brain disorder has

led across history to an inflation of the heritability statistic and coercive forms of treatment and that what were attempts by psychiatry to become a legitimate, viable branch of medicine are now considered grave historical embarrassments (Bentall, 2010). Others have contested that modern day mainstream psychiatric practices can lead to psychiatry overlooking experiences of psychosis in the context of a person's life (Boyle, 2002).

Any assumption that all psychiatrists subscribe solely to a biological framework to understand psychosis are also overlooking the role of the *Critical Psychiatry Network* (CPN) whose members have promoted moving beyond a traditional medical model (Bracken *et al.,* 2012; Double, 2002). The CPN also challenges the legitimacy of any one group having authority over the nature of psychosis (Bracken, 2014). The position held by many identified with critical psychiatry is the unsuitability of identifying troubling or adverse states of mind with medical terminology (Moncrieff & Middleton, 2015). Supporting their argument is the failure to identify distinct defects in the structure or function of the brain as directly relating to psychosis despite one hundred years of bio-medical research (Moncrieff & Middleton, 2015). Even those involved in neuropsychiatric-genetics research have summarised how Kraepelin's *original* dichotomous diagnostic classification system appears biologically implausible (Craddock & Owen, 2010). Recently, the prominent psychiatrist, Sir Robin Murray publically stated that he ignored social factors in "schizophrenia" and called for more research on environmental factors and epigenetics (Murray, 2017). He said that those still clinging to a Kraepelinian model were refusing to accept the evidence base with pernicious consequences for their patients, a point raised previously by Joseph (2013). Arguably, Kraepelin thinking is still in evidence in mainstream psychiatry and appears to be somewhat sanctified in clinical practice and research.

This sanctification of Kraepelin thinking suggests mainstream psychiatry may be

unable to embrace the view of psychosis as a contested area, as recommended in the BPS/DCP report.

The aims of the study were to:

- Explore if, and how trainee or qualified psychiatrists had been influenced in any way by the DCP/BPD document "Understanding Psychosis and Schizophrenia," particularly with respect to how it promotes psychosis as a contentious area.
- Explore if and how they had been influenced by the Critical Psychiatry network within their practice.
- Utilise a Critical Narrative Analysis approach (Langridge, 2007) to engage with narratives elicited by participants related to psychosis as a contested area and to draw out the rhetorical function, tone and identity work within these.
- To bring out themes, engage a hermeneutic of suspicion and form a critical synthesis.

METHOD

APPROACH TAKEN AND EPISTEMOLOGY

A qualitative research design was selected because the focus was on engaging with and understanding the position and the views of psychiatrists with respect to the topic. The qualitative design chosen was informed by a dialogical-contextual-constructionist epistemolog*y*. In-depth data from a small sample was designed to draw out narratives, insights and themes rather than test any formalised hypotheses through much larger samples. Verbal dialogue was emphasised over

any numerical aggregation of data. Further details relating to the design, approach taken and epistemology is included in **Appendix A.**

PARTICIPANTS

Participants were recruited once Ethics approval was obtained in February 2016 **(Appendix B).** Recruitment initially took place within an NHS Trust where the researcher and her supervisor worked. Prospective participants were contacted via email or letters of invitation. The intention was to gain a broad range of viewpoints. Subsequently, approval was sought from two other NHS Trusts to try to increase the sample size and the range of perspectives (**Appendix C**). The three Trusts fell within a Royal College of Psychiatry regional organisation responsible for psychiatry training, known as a Deanery. Given time constraints balanced with the notoriously time-consuming and arduous nature of the analytical process used, as outlined by (Langdridge, 2007), the sample was intended to reflect divergent perspectives rather than saturation. Inclusion and exclusion criteria for participants are outlined in **Table 1**.

TABLE 1: INCLUSION AND EXCLUSION CRITERIA

Inclusion criteria	Exclusion criteria
Have completed an undergraduate medical degree.	At undergraduate or foundation level of medical training.
Working within/on rotation within one of the three Trusts for which R&D approval had been granted.	Working in an NHS Trust where R&D approval had not been granted.
Have a minimum of six month's experience working with psychosis.	Less than six month's experience working with psychosis.
Have understood the nature of the	Consent not given or withdrawn and/or

study and given informed consent prior to participation.	study not understood.

The sample included four post-graduates at trainee level and eight at qualified level comprising a sample of 12 in total. Demographic information is summarised in Table 2. Any breakdown of demographic information, including age or specific ethnic groupings has been omitted after careful consideration, to protect participant identity**.** Participation followed informed consent prior to which all participants had a copy of the study information sheet **(Appendix D).** The researcher endeavored to protect the rights, privacy, dignity and sensitivity of participants in-keeping with the British Psychological Society ethical guidelines (BPS, 2009).

TABLE 2: DEMOGRAPHIC INFORMATION. ALL NAMES ARE PSEUDONYMS.

Order in which interviewed	Participant pseudonym	Level within psychiatry	Gender	Broad Ethnicity
Fourth	Pippa	Trainee	F	White
Twelfth	Finn		M	Asian
Second	Lucy		F	White
Sixth	Iqbal		M	Asian
First	Nilesh	Qualified	M	Asian
Seventh	George		M	White
Tenth	James		M	White
Eleventh	Alice		F	White
Ninth	Ben		M	White
Fifth	Don		M	White
Eighth	Ian		M	White
Third	Prisha		F	Asian

PROCEDURE

Data was collected through face-to-face semi-structured interviews between March and November 2016. Interviews varied in length from one hour to two hours and forty minutes. The average interview duration was one and a half hours. All interviews were transcribed by the researcher to facilitate immersion in the data (Maykut & Morehouse, 1994). An interview guide was flexibly adhered to **(Appendix E)**. Questions were avoided which might have been counter-productive to an interviewee feeling settled, listened to and understood or rapport being established (Langdridge, 2007). The key characteristics of the interviews were to conduct an in-depth exploration of the topic with participants and obtain detailed responses preferably of a narrative quality. Interviews typically commenced with establishing current and previous roles, choice of psychiatry and their experience of working with psychosis. During interviews participants were asked about their familiarity with the BPS/DCP document, questions designed to elicit their thoughts with regards to psychosis as a contested area and questions designed to establish their own position. Participants were also asked about their knowledge of or membership of the *Critical Psychiatry Network*. During the interview, any discourse which seemed relevant or which the researcher had not thought of during the production of the interview schedule were responded to (Charmaz, 2014; Langdridge, 2007). Participants were also asked questions related to their identity, particularly where it related to the topic.

The data analysis followed the *hermeneutic circle* of Critical Narrative Analysis (CNA), as described in detail by Langdridge (2007: pp.134-140) and illustrated in **Figure 1**. The rationale for the use of CNA over other qualitative approaches related to how CNA attends to identity, rhetorical function and social theory,

enriching a more complex understanding of the data, allowing the researcher to both access wider meanings and use these to analyse the data, whilst also considering their own viewpoint. Further details related to the choice of CNA can be found in **Appendix A** and will be revisited in the Critical Appraisal section of the thesis. CNA could be considered an integrative form of qualitative analysis, which incorporates ideas from narrative, thematic and discourse analysis.

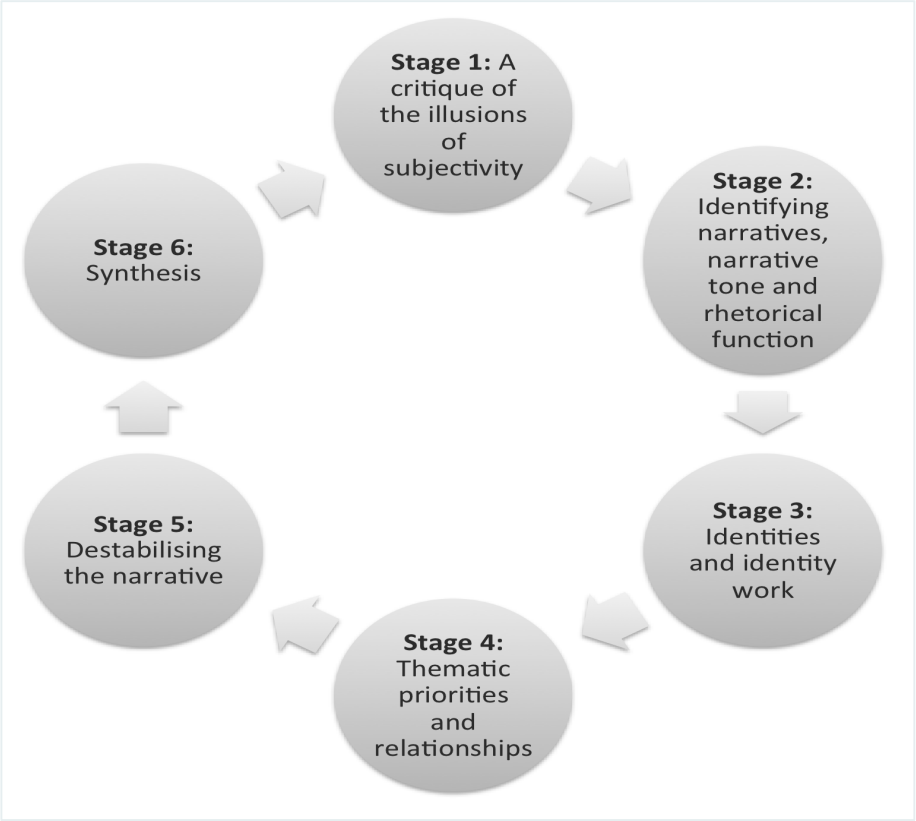

FIGURE 2: THE HERMENEUTIC CIRCLE OF CRITICAL NARRATIVE ANALYSIS

RESULTS

STAGES 1: CRITIQUE OF THE ILLUSIONS OF THE SUBJECT

The researcher subjected herself to a critique, thinking about her own views, beliefs and experiences and the influence these might have had on her understanding of the topic. To draw this out, she also took part in a bracketing interview facilitated by her research supervisor in May 2016 (Langdridge, 2007). The purposes of the bracketing interview was to elicit the researcher's reflective stance (Tufford & Newman, 2010). An extract from this is included in **Appendix F.** The purpose of the bracketing interview was to attend to experiences, inevitable pre-conceptions, assumptions, values and biases held by the researcher, which could potentially influence how the data was gathered and interpreted so that in-depth reflection would improve the analysis and results (Tufford & Newman, 2010). The researcher gave consideration to how her own biases might have influenced the process and kept a reflective journal during the research (**Appendix G**).

STAGES 2 AND 3: IDENTIFYING NARRATIVES, NARRATIVE TONE, RHETORICAL FUNCTION AND IDENTITY WORK

Any distinct narratives relevant to the topic of interest within the text were identified; narratives were defined as having a clear beginning, middle and end.

This stage also involved identifying the *functions of the narratives,* for example,

whether they attempted to persuade or justify a position or imply a criticism of another. This is known as the *rhetorical function.*

The tone was also attended to which related to *how* the stories were told. How people constructed themselves through their narratives were picked out to inform identity work.

Langdridge (2007) describes the separation of stages two and three as somewhat artificial and they have not been separated in the current analysis. The reason for this was that several readings of the text highlighted that identity work was clearly woven into narratives; separating them into separate sections seemed a less coherent approach.

Any name or narrative which might identify any person has been either changed or omitted. Decisions about what to include were informed by the aims of the research and epistemological position.

This following section offers a synoptic, condensed overview of each of the interviews and includes relevant narratives for each person, as well as the tone, rhetorical function and identity work. Participants have been ordered from most bio-reductive to least bio-reductive/most critical in the results section. The purpose of this was to organise the narratives in a way that fitted with what was emerging from the data, that is, that there were three distinct groups – biological, critical, and a third group who were less clear.

PRISHA

Prisha was a consultant psychiatrist who identified as a biological psychiatrist. Prisha shared a professional narrative of her time training and working in Southern Asia where she had experienced a "feeling of gratitude and thankfulness for a

realisation of how far we've come" (129). She felt the profession had moved on from old-fashioned treatments in asylums. During her time as a trainee she identified a "distinct hierarchy" where one did not "challenge your consultant…..there is a very yes sir, yes madam environment" (496-497), where the "biological perspective" (509-510) was emphasised. The tone of Prisha's narrative was explanatory; she sought less to persuade than to explain. She was steadfast in her rhetoric and did not think anything "stands out as being contentious" (391). She also said that she had "not come across anyone who had hugely differing opinions that I have to challenge them" (501) referring to other psychiatrists or trainees. She aligned herself with the biological model nineteen years ago and believed in it because it "definitely works" (268). She identified her role was to "clear up" "misconceptions" (257), to give patients and their families a "clear understanding of why it's happened based on the evidence base" (258). She shared that no-one in her immediate circle of psychiatry colleagues would "not subscribe" to "the biological model" (421), which was reflected in how her peer-group comprised those who "consolidate each other instead of challenging each other" (457). For Prisha, psychosis is the "most straightforward….the most straightforward group to treat" (396-397). She attributed this to the "clarity" of what "you're treating and how you've got to treat it" (400-401).

PIPPA

Pippa was a core trainee. She also identified herself as a biological psychiatrist. Pippa was the least talkative interviewee and her interview was comparatively short. The narratives were also less defined, and many of her responses were quite perfunctory. The tone of Pippa's narratives was wary and uncertain, particularly during attempts by the researcher to draw out narratives or to encourage her to qualify her position. Pippa's rhetoric positioned her as unquestionably accepting the information given in training, someone perhaps unaware of other positions.

Pippa shared a professional narrative of learning about multiple diagnoses from a consultant. She described this as "the hierarchy of diagnoses" and talked of going on to "diagnostically work through things" (219-220). At both undergraduate and postgraduate training, and amongst senior colleagues, she believed there to be a convergence that psychosis is caused by excessive dopamine and that it is treated with anti-psychotics. She also said that she could not think of anything that she had come across that differed from the dopaminergic-hypothesis. She constructed her professional identity as someone who wholeheartedly trusted her training and accepted the ideas she was taught. The professional role she constructed was someone whose job was to identify symptoms and correctly diagnose.

IAN

Ian was a consultant psychiatrist who identified as a biological psychiatrist. The tone of Ian's narratives early on was earnest and resolute. Towards the latter stages the tone was more relaxed and reflective. At times his rhetoric assumed an explanatory, justificatory function. For much of the interview, he was unequivocal about biological reductiveness. In the latter stages of the interview, after his rhetoric about biological reductionism had dissipated, he introduced his professional identity as someone who was keen not to pathologise, label people or prescribe medication where possible. He said he was "trying to get them out of the system as much as possible" (819-820) and found himself being "less negatively critically judgemental about people" (823) which inferred a criticism of a more critical, judgemental psychiatrist. There was a personal narrative about an asylum local to him growing up where a family member had worked and where he had spent a lot of time as a boy. It was somewhere he had only happy memories of. A lot of the central narratives were around arguments for a biological understanding of psychosis. For Ian, much of psychosis is "ultimately reducible to brain chemicals" (384-385) and "reducible to biology" (393-394), that everything

can be “explained at a molecular level as long as you’ve got the knowledge” (395-396), and that “the genesis for a start is more biological than social” (904). At the very end of the interview, he said that he had “gone down this quite hard line of saying you can reduce everything if you want to” (1100-1101), which he felt had “negated…obscured the extent to which I feel psychological thinking is very, very important” (1102-1104) but that he had not vacillated between the two because he knew where he stood. Ian wove into the narrative the identity of himself as a conscientious healer, who was doing something truly meaningful in his life now, and who got “self-validation” (973) from “being useful to people” (974). His identity was “very caught up in being useful, helpful” (987).

IQBAL

Iqbal was a senior trainee (ST5). The tone of the narratives was quite muted and strained. Iqbal rarely elaborated on anything he said. He appeared to draw from textbook definitions. As the interview progressed, Iqbal’s rhetoric became increasingly perfunctory and axiomatic. The possible reason for Iqbal’s rhetorical position was that he had no experience of being challenged about his views “with regards to psychosis, no” (462). He suggested that psychosis might be contentious in the “psychology world….but not in the psychiatry’s” (544-545), the latter would be happy “prescribing and managing, ye, with anti-psychotics” (547). He appeared to hold on to two different etiological pathways to psychosis, the “purely biological” (138) and “past trauma” (136). He concluded he had “both views on it really” (157), that it was either biogenic or traumagenic. There was a professional narrative to support his ideas, one which was about a girl who he had worked with in a therapy context. Iqbal outlined the way expressed emotion in this family manifested itself with the result that the girl “couldn’t progress” (277). He felt this led to her experiencing a second psychotic episode. His views about traumagenic etiology was supported by his experience of working with people of migrant or

refugee status from Iran, Iraq and Sri Lanka whose psychosis clearly linked, for him, to their experience of trauma. “This was the result of sort of being through particular experiences, of being, whatever the trauma was” (315-316). There was another professional narrative about a second girl, this time in an inpatient service. Iqbal felt “it was quite clearly trauma and this was about what had happened to her earlier in her life” (326-327). Iqbal appeared to accept what he read in textbooks, “they give you very hard facts…studies that have been done and genetic studies, twin studies that have been done….when good textbooks were quoting that sort of thing, it’s really hard not to believe that I guess” (236-238). In Iqbal’s experience, anti-psychotics provided “instant results” (550) and “always worked” (592). They “reduce the level of dopamine” (563), by rectifying a “chemical imbalance in the brain” (564-565). His ideas about trauma did not appear to be integrated into these biologically reductive ideas which emerged towards the latter stages of the interview. He did not expand on the complexity or contradictions inherent in this. Iqbal was disinclined to bring a sense of his identity into the narrative. He said that “there isn’t anything that would influence my views on psychosis I guess’ (350-351) with regard to his own values and beliefs.

Lucy

Lucy was a senior trainee. She too identified as a biological psychiatrist. Lucy’s narratives were often short and unembellished. The general tone of her narratives was confident and matter-of-fact. When speaking about incorrect, changing or unnecessary diagnosis there was a tone of frustration. Lucy’s narratives around psychosis were about adopting a biological perspective which had its origins in training where there was emphasis on receptors, types of psychosis and treatment, side effects and debates emphasising diagnosis. Lucy told a narrative about more recently, having some exposure to other perspectives through undertaking a course. “So I find that is quite interesting. We don’t talk much about

psychosis, but sometimes that does come into it. That is quite good an opportunity to get other peoples' views about things" (186-188). There was a second narrative about going to a conference where Lucy heard about a different perspective, one which was about using an avatar with voice-hearing which made Lucy think about how there might be "more to it than that if you can actually talk to a voice" (239-240). The function of Lucy's rhetoric was to position her as different to those who spend their time pursuing correct diagnoses or reductive neuroscientific research, those who try to make psychiatry more of a scientific speciality. She portrayed these psychiatrists who were more involved in academia as overly focused on establishing a biological science. Lucy both aligned herself with a biological understanding of psychosis whilst also criticising an *over*-alignment with this position. She spoke about an absence of psychology depriving her of the opportunity to test her theory as to whether, in some instances, psychosis is driven by underlying experience. She explained that psychology's waiting lists are long which she felt was demoralising for her patients; "access is really limited for people with psychosis. It's limited enough as it is. It takes like a year waiting list to get to CBT and psychodynamic therapy already" (263-265).

NILESH

Nilesh was an associate specialist. His position was mixed. There ran throughout the interview a tone of earnestness and sensitivity, particularly to spirituality and areas of uncertainty. Nilesh shared many narratives. There were narratives about spirituality including one about a patient who eventually stopped sharing her spiritual experiences because she was on the verge of being sectioned and how Nilesh felt sad about this. There were narratives about personal revelations he had had at conferences he had attended. At one, he was exposed to ideas from the Hearing Voices Network and had been particularly struck by a talk about unresolved traumas in psychosis. At a second conference he had been impressed

by the discovery of particular genetic variants. He had also attended talks from psychiatrists involved in the *Critical Psychiatry Network* about the use of medications. There were several professional narratives about a clinical psychologist who lent him books related to critical psychiatry which he had found "quite revealing" (392) and later they had "extended interactions" (724-725). The rhetorical function of Nilesh's narratives were to position himself as someone not wishing to "get too caught-up in one explanation because there are lots of things." He refrained from any rhetoric aligning himself with any group, organisation or understanding of psychosis, but was incorporating the views of all into his own position. He portrayed his identity as very much "still learning" (587) and "reading around the fringes" (619). He spoke about being very "interested in finding out more" (364) and wanting to "solidify" (544) his position without identifying himself with any particular group. He constructed through his narratives his identity as someone who, because of his spirituality would never uphold a bio-reductionist approach and would always wish to incorporate a psycho-social-spiritual framework. He described the "soul of a person is where the emotions and experiences take place and the brain of a person is where those experiences and emotions are reflected" (827-828). He was disappointed that he did not have the scope for his spiritual nature to impact upon his practice.

George

George was an associate specialist. There were multiple narratives within his account. The tone of George's narrative was very thoughtful, self-reflective and open. There was a canonical narrative (i.e., a narrative representative of broader social stories) about people with psychosis being "sort of deranged and mad" (196). This was developed, touching on how psychosis "doesn't lend itself towards the sort of collaborative discussion about meaning" (204-205) and identifying the person as "sort of mad and the person gets lost in it" (210-211). When faced with

psychosis he felt rendered "somewhat helpless in thinking about what you can do here" (280-281). There was a personal narrative about a family member who had worked in a psychiatric hospital, a place having a "frisson of danger" (831) about it and a look of "foreboding" (832). A second, extended family member had had a "psychotic breakdown" which had caused "a lot of disturbance in the family" (835) when George was in his early-teens. At the time, they had extra-pyramidal side-effects from anti-psychotic medication and there was a sense that it was "game over, life over" (845). George had been "kept away from it" and heard it talked about it in a "hushed and anxious way" (962-963). His "fears and anxieties" (842-843) had been shaped by this, and that, growing up, within the family, it had been thought about as a "sort of genetic flaw" (982), which developed into another canonical narrative about inferred "bad stock" about how "we distance ourselves from the things we're fearful of" (990-991). He constructed his identity within the narrative as a person who was a reflective learner, someone who was continuously developing as a person. Through his work and his patients, he was as much interested, it seemed, in self-reflection and developing his own person. He spoke about being drawn to the work, in part, because "I think I needed to sort some stuff out for myself" (129). George positioned himself rhetorically as the curious wanderer. His honesty at times was unadulterated, particularly how he related to canonical positions. He admitted he had a "preference for not working with psychosis" (223) and was "almost ashamed to admit" that he "engages dismissively with people with psychosis" (1173-1174). He admitted he had "at some level…probably readily accepted the literature, explanations for psychosis that are currently prevalent" (334-336) and that he could "argue that I occupy a defensive position in defending the positions that doctors and ideas in medication take on" (567-568).

FINN

Finn was a trainee, working as a locum, unsure if he would continue to pursue a career in psychiatry and as a result some of his narratives were not always related to the topic. He was also developing his position on psychosis. The tone of Finn's narratives was animated. He had been learning on a management course about the "5 Why's," something that really resonated with him when it came to psychosis. "If you keep asking why, why, why, why, why, you'll eventually get to the crux of an issue" (925-926). Finn's rhetorical work seemed to position him as someone grappling to make sense of the things he was struggling with in psychiatry. He positioned himself as someone who would either get his "head around" (193-194) aspects of psychiatry, or continue to "question it more" (194). Finn's rhetoric around questioning featured throughout the interview. He spoke about approaching consultants and questioning, why, for example, someone was still in a service where he was working and thinking carefully about how he would feel if he was asked the personal questions patients are asked on a daily basis. Finn's experience was that his questioning attitude was actively encouraged by his seniors, which is why, perhaps, his rhetoric was neither cautious or defiant. Indeed, he indicated that he thought other psychiatrists were of the same viewpoint as him and he assumed that more experienced psychiatrists had the answers to the various complex conundrums he was facing because of their relatively additional experience. Finn constructed himself as someone who questioned things, the "new kid on the block, just a bit eager and questioning" (166-167), someone who would "take a step back" (312) and think about what the experiences of his patients were like. He held on to uncertainty "there's no concrete answer" (245). He ventured that only "personal curiosity" (618-619) would allow someone to deviate from a bio-reductionist view. He said "I struggle to, just accept things" (923).

BEN

Ben was a consultant psychiatrist. His interview was very lengthy, with numerous narratives so only those particularly relevant are discussed here. The tone of Ben's narrative was unconstrained and exuberantly oratorical. It seemed that the function of Ben's rhetoric was to argue for and against different perspectives. He was very informed about different models of understanding psychosis and he weaved in and out of describing evidence for or against them. In his day-to-day practice he seemed to focus on problems and defining problems as a starting point. He raised concerns about those who "do see it (psychosis) as straightforward" as they "ignore huge chunks of evidence" (638) and "are part of the problem" (642). He offered them a caution, because, at one time, people were "very sure that frontal lobotomies were the way to sort things out" (642-643). Ben, identified himself as a "pragmatist" (404) who did not "adhere to or believe in (any one) particular model" (405) to understand psychosis, interested mainly in what worked for his patients. He brought into the narrative a person unlikely to be happy assuming a position that says "I'm the expert and I'm right" (430-431). There was a personal narrative related to uncertainty about etiology in psychosis. This was about a post-graduate mentor of his who had once been very "sure" (835) about his theory and then later admitted he had been wrong. He commended him because "walking away is very hard" (996) and went on to say that "advances in science are marked by funerals" (889) meaning that there can be progress when the power held by some individuals dissipates. He constructed through his narratives someone who exercised an "intellectual humility about any position" (415-416), someone not naturally optimistic. He believed that knowledge about statistics and the philosophy of science allowed for better critical engagement with the evidence base, which was something that he appeared to value.

JAMES

James worked as an associate specialist. The tone of the narrative was intense and emotionally-engaged. There were numerous narratives so only the most salient are described. There was a professional narrative about a psychoanalyst who he greatly admired, who, at complex-case discussions, would have his views "get routinely rubbished' by consultants, (541). Afterwards, the same consultants would approach him to get advice. This was, for James, an example of how the consultants needed to "reassure their juniors" that they could understand and work within the bio-medical model, which at times required them to "belittle alternative explanations" (548). Rhetorically, James brought into the narrative uncertainty both about explanation and what is helpful or unhelpful. He positioned himself as less defended against uncertainty than others. He spoke about how hard it is to "say who is helping more and who is harming people more" (338-339), the "people who happily sit with the medico-reductive model" their "whole careers" (337), or those who, like him, maintain more uncertainty, those who stay with the complications, the "poorly understood" (344) aspects. Towards the latter stages of the interview he placed greater emphasis on criticisms of fixed bio-medical positions which he considered "unthinking….simplistic understandings of the human condition…I know they're wrong" (905-907). His view was that traditional "treatments for psychosis are crude" that they "hardly takes a sideways look at consciousness, or ….human experience" (193-195). He became more explicit about this when he described some psychiatrists "and their kind of wilful, malignant ignorance really in the way they go about their business" (947-948). James constructed himself as "reasonably emotionally open" (848-849), someone who had sought life experiences and worked hard at developing himself as a person. For James, everything "about me and everything about my history is absolutely vital to my practice as a psychiatrist" (667-668), that "every human experience that you have influences what you do" (682-683).

ALICE

Alice was a consultant psychiatrist. The tone throughout Alice's narratives was reflective, compassionate and placid. There was a key narrative in the context of Alice's position of gravitating towards non-medical models. On the last day of a large conference she attended, when she went outside, there was a "great big gang of people dressed up as the Grim Reaper marching up and down with placards". For Alice, it had been "quite a painful thing" (277). Even when she was being shouted at outside conferences, she still felt compassion towards the protestors and spoke about how "important people who've had that experience are allowed to voice that" (278-279). Alice and a friend were both struck by how much the presentations were about "genetics….very biological and all very reductionist" (292-293). They undertook research to demonstrate this. Over time, she became more and more involved in service-user movements and teaching. Alice also shared how, as a child, she had reverted to her imagination a lot so a adult psychiatrist, this lent itself to her being better able to "tolerate….people being in different worlds or having difficult experiences" (611-612). Alice described growing up "between two worlds" (903) she was "always a bit on the outside, looking in" (934-935). The rhetorical function of her narratives was to position herself as someone who considers multiple perspectives and as "open to new ideas and being flexible about how you might be able to help somebody" (454-455) perhaps against those who are "very reductionist, biological … is a chemical imbalance and needs medication, stop faffing around" (465-457). She was compassionate rather than critical towards those who subscribe to biological psychiatry; she believed there was "room for all of those ideas" to "not necessarily grate against each other" (465). Her vision was to "see people coming together, bridging that gap and working together to think about things differently" (468-469). Alice felt it to be unfortunate that "you don't often see the two mixing…easily or comfortably" (476). Once again, Alice exercised compassion and

understanding saying it “can be quite painful….to let go, to go in the other direction” (481-482).

DON

Don was an consultant psychiatrist. He identified himself as a critical psychiatrist. The tone of the narratives was generally mellifluent, sure-footed and confident, exemplified by him saying “I would carry the view it’s extremely unlikely that I’m wrong” (969). As the interview progressed, the narrative tone shifted to becoming both more unyielding and irreverent. Don’s narratives centred around his perspective on psychosis, “one which really does overtly say the fact that this person is in difficulties is not because there’s something wrong with them, but because there’s something unsatisfactory and perhaps malfunctioning about the social microcosm that they’re inhabiting” (724-727). There were several professional narratives - during his career he had encountered “quite a lot of service user activists” which helped him understand “there’s more to this than dopamine receptors.” He spoke about how critical psychiatry is often conflated with anti-psychiatry, something Don describe as an “interesting bit of propaganda” (343) which served to “shut down any helpful conversation” (440-441). Rhetorically, he contrasted himself to those who, unlike him, “avoid going to places where you might get shouted at” who, in effect, go to “the bio-medical psychiatry conferences and live in a bubble” (313-316). Don was often arguing against what he called the establishment, who quash descent. He constructed his identity as part “of the awkward squad” (406), someone who “risks professional censure” (408), who sacrificed the “same conventional career success” as peers who would have “stayed with bio-medical psychiatry” (416). He described a “healthy disrespect for authority” (434), the origins of which he traced back through his family; at school he sensed he had “covert parental consent to be a rebellious boy” (495-498). He felt he was in a better position than those who are actually frightened to “put their heads above the parapet” (533) because of his

background and where he was educated. He felt his faith and psychiatric practice had been brought together over the last ten years and positively influenced his professional life.

STAGE 4: MAIN THEMES

This stage involved the identification of themes and relationships between themes. Themes were identified through repeated systematic reading of the text. Key sentences and phrases were picked out of the text, without breaking the text apart and coding every unit of meaning (Langdridge, 2007). The researcher's own views and opinions on the topic were reflected on and engaged with during this process. The text was returned to repeatedly to refine themes and to explore further relationships between them. The most prominent themes relevant to the topic that developed from the analytical stage are outlined below. Quotes from individual participants are included to illustrate the pervasiveness and importance of each theme. There were ***five themes***.

The first was ***conventional orthodoxy*** within which there were four sub-themes – ***bio-reductiveness, progression, damage*** *and* ***simplification***.

The second theme was ***invulnerability and expectation***, within which there were three sub-themes – ***expert with the answer, being the doctor*** and ***invincibility of the doctor***.

The third theme was ***power, disempowerment and populism***, within which there were four sub-themes – ***powerlessness in the bigger system, policing orthodoxy, career progression*** and ***popular discourse***.

The fourth theme was ***dampening creativity***, within which there were two sub-

themes – ***hard sell orthodox ideas*** and ***creativity reined in***.

Finally, the fifth theme was ***space and reflection***, within which there were two sub-themes – ***demands and systems limiting space for reflection*** and ***attitude to models that provide space for reflection***.

Conventional Orthodoxy

A theme that permeated most of the interviews was ***conventional orthodoxy*** **(see table 3*)***. There were a range of positions with respect to this theme. On the one hand, there were there were those who adhered to ***bio-reductive psychiatry***, for whom genes and genetic vulnerability were things that they embraced and on the other hand those who were much more cautious and critically engaged with these ideas. Most participants mentioned prescribing anti-psychotic medication as being part of mainstream orthodox practice and a key part of their role. There were three sub-themes within this – ***progression, damage*** and ***simplification***.

Table 3: themes related to orthodox psychiatry

Theme	***Sub-themes***	***Source***		
		Aligning with	***Critiquing***	***Both aligning and critiquing***
Conventional orthodoxy	***Bio-reductiveness***	Prisha Pippa Iqbal Lucy	James Alice Don	Finn George Nilesh Ben Ian
		Referencing evidence of	***Referencing lack of***	
	Progression	Prisha	Finn George Ben James	
	Damage	Ian		

		Nilesh James Don	
		Referencing evidence of	***Identifying with***
	Simplification	Ben	Prisha
		James	Pippa
		Don	Iqbal

There were several participants who accepted ***bio-reductive ideas*** which they felt represented the most up-to-date evidence base and was a sign of progressiveness. They had been taught a lot about neurophysiology during their training and continued to apply this knowledge. They trusted their training.

Prisha: *"….it is dictated more biologically, chemically, and by genetics"* (293).

In contrast, others spoke more about how this kind of biological reductionism stems from an unhelpful assumption that if something works on a receptor that this is representative of imbalances in these receptors. They considered this representative of a lack of ***progression*** within the field, that psychiatry is a conservative institution.

James: "*Psychiatry is staggeringly conservative …. We're not lopping out frontal lobes anymore, just about and…. are on some level exposing patients to harm. Most institutions would tend towards the conservative if they've been around long enough… even a Progressive Society of Psychiatry would, after ten years, have stultified into committees and movements and politics and status*" (589-599).

This linked to a subtheme of ***damaging,*** particularly how it related to both psychiatry generally and more specifically, the use of diagnoses and coercive treatments. This seemed particularly pertinent when people were transitioning from early intervention services to adult services and when psychiatrists were obliged to use ICD-10 codes when corresponding to GP's. The concern was that this indicated that there was a value being placed on diagnosis and that it possibly stemmed from the relationship between doctors and drug companies. This was described as damaging to people, along with the prescribing practices around anti-psychotics medications.

George: "one controversy in psychosis is ehm….you know, it's one that drives pathologising it a ruse to keep doctors at work and keep drug companies and their share-holder's wealthy" (laughs) (561-562).

Simplification emerged as another sub-theme, how, for example, definitions of psychosis are still being used that were invented over a hundred years ago.

James: *"reductive, crude, simplistic, more likely to be damaging than helpful" (197-199)*

There were those who explained psychosis as relating to excessive dopamine, which informed their management and prescribing practices. Others believed that one of the principle reasons for the dominance of the dopaminergic system theory is that it offers a convenient simplification which became a very popular way of thinking.

Don: "*all we can do without drugs is put the chemical into the person's blood stream and hope that it gets into the head somehow. And that, you know, that makes sledge hammers and walnuts look like a refined instrument doesn't it*

really… (chuckles), but we still persist with the myth that we know what these chemicals are doing, and we continue to pedal the idea that when somebody has a mental health problem, it's because something has gone wrong with their brain, and the right thing to do is to put that 'right'... And of course, by applying the over-simplification that this is just something wrong with somebody's brain, we immediately avoid having to ask all those difficult questions, we provide what looks like a very simple solution to the problem and we don't address the problem at all, because we've avoided it by doing that." (lines 183-198).

Invulnerability and Expectation

The position of the doctor as ***invulnerable and under expectation*** featured repeatedly**.** There were several sub-themes within this broad idea **(see table 4)**.

Table 4: Themes related to invulnerability and expectation

Theme	***Sub-themes***	***Source***	
		Aligning with	***Critiquing***
Invulnerability and Expectation	***Expert with answer***	Prisha Pippa Lucy Finn Nilesh	Ben James Alice
	Being the doctor	Prisha Finn George	Ian Nilesh Ben James
	Invincibility		Alice James

The first subtheme was concerned with psychiatrists being positioned as the ***expert with the answer***. Junior psychiatrists seemed to have internalised the idea that senior colleagues were experts, people whose views they would not challenge

because they perceived them as more knowledgeable and experienced and who would have the answers and the final say about someone.

Lucy: "Because they're so much more an expert than you that you can't really discuss things." (360)

In the workplace, in teams and in Trusts, psychiatrists overall seemed fearful of not responding to requests to *do* something about a situation, with the result that they were often fearful of reducing medications or taking a less conservative approach with people.

Ben: "…I get presented with someone and I have to do something and I have no choice, you know. …. The system effectively says "fine, you've gotta do something, it's your job. You're the end stop. You're the catcher's mitt under this particular system. You've gotta do something." (507-511)

There was a second sub-theme about ***being the doctor***, a role synonymous with having power, and not being able to present oneself in anyway as uncertain or vulnerable. Once a doctor, it was difficult to diffuse from this identity. This brought pressure to know, to have the answers and to also work under wider pressures, to demonstrate to the Care Quality Commission and the Trust that you are doing what you are *supposed* to be doing.

Alice: "….there are different views about how much you present yourself as a human rather than just the doctor" (137-138).

This tied into a third sub-theme, the ***invincibility of the doctor.*** This related to popular discourses about doctors as always present, never sick and carrying on regardless. It was suggested that given the weight of responsibility of the role, a

way to cope with the nature of the job is to defend against it, to reassure even themselves that they could cope. This was something that permeated their profession to the extent they were not even looking after each other because expressing vulnerability was unwelcome.

James: "I would say that psychiatrists generally do not enjoy sharing vulnerability or showing vulnerability…. the psychiatrist as a clinical leader needs to contain and reassure their team as well as contain themselves. …. perhaps pretend they know exactly what's going on and what will happen." (68-74)

Power, Disempowerment and Populism

The theme of ***power, disempowerment and populism*** came up strongly across the interviews, separated out into several sub-themes **(see table 5)**.

Table 5: Themes related to power, disempowerment and populism

Theme	***Sub-themes***	***Source***	
		Aligning	***Critiquing/contesting***
Power, disempowerment and populism	***Powerlessness in the bigger system***	Lucy George Ben Alice Don	
		Recognising	***Critiquing***
	Policing orthodoxy	Pippa Lucy	Ian George Nilesh Ben James Don
		Accepting status quo	***Critiquing status quo***
	Career progression	Prisha Nilesh	Lucy Finn Alice

			Don
		Commenting on	***Critiquing***
	Popular discourse	Finn George	Don

One of the sub-themes was about ***powerlessness in the bigger system***. The power experienced in a one-to-one clinical appointment and the power to detain people under the Mental Health Act contrasted with the powerless experienced within the wider system, where the participants felt unable to have influence. This system for interviewees went right up to government level.

Alice: "… it's foolish also to sort of pretend there isn't a power difference because of course there is, and we do have the Mental Health Act and I guess we're seen as powerful. The irony is that, a lot of consultants don't feel that powerful because, in the system as it is, when we see things happening, and we want to change things and we see things happening to services, we often can't do anything whatsoever. We actually feel quite powerless a lot of the time. But I can imagine from a patient-doctor perspective, we're viewed as having that power." (566-572)

The second sub-theme was about ***policing orthodoxy,*** something occurring within psychiatry itself, with views outside mainstream orthodox psychiatry kept on the periphery. More critical psychiatrists spoke of an authoritative hierarchy within the medical profession reinforcing biological conceptualisations during training. This also seemed to be perpetuated by expertise and seniority being internalised at trainee level, that someone at a consultant level would be seen as someone to be deferred to.

Nilesh: "I know the first time I applied for study leave to go to a Critical Psychiatry Conference, I wondered 'is this going to be accepted by the panel?' (laughs) …. …. (that) we'll start corrupting the patients and stop giving anti-psychotics to the patients. I was thinking it might be not accepted because of some sort of paranoia on the establishment's part" (642-650).

The sub-theme of ***career progression*** considered how the relationship between psychiatry, pharmaceutical companies and universities bolster bio-medical science, which becomes a good way to self-advance. The suggestion was that those intending to establish or defend psychiatry as a scientific speciality had greater profiles in psychiatry often with links to academia. Their views carried more weight and prominence. Those who challenged this or who promoted alternative frameworks for understanding psychosis rarely had the same career trajectory, encountering opposition or even censure.

Lucy: "…..They're the people that are more interested in, kind of, getting themselves known for certain things or doing research and that kind of thing. Yes, so I think maybe people that are more interested in the biological side of things are more driven to kind of putting themselves out there, a bit more, academically" (432-440).

One of the things which also protected orthodoxy was ***popular discourse***, which positions psychiatrists to work conventionally, something which carried on because of how someone with psychosis might be experienced within a wider social context.

Don: "So….. that knowledge becomes part of the lay-discourse, and how that lay-discourse in itself determines what professional practices are, or at least sets constraints around professional practices. You know, I can only get away with

offering something that is slightly unconventional. If I was to do something very unconventional, even though I was in my own mind, completely convinced that this was a good idea, I'd probably have difficulty getting that accepted, ….. what doctors can and cannot do is actually quite tightly constrained, their offices if you like, our wider social system, which has its own views about how things should be dealt with." (226-235)

DAMPENING CREATIVITY

Dampening creativity was separated out into two sub-themes, the first of which was ***hard sell orthodoxy*** and the second was ***creativity reined in*** **(see table 6)**.

TABLE 6: THEMES RELATED TO DAMPENING CREATIVITY

Theme	***Sub-themes***	
		Acknowledging
Dampening creativity	***Hard sell orthodoxy***	Prisha Finn George Nilesh Ben James Alice Don Pippa Iqbal Ian Lucy
	Creativity reined in	Finn George Nilesh Ben Alice Don

The interviewees spoke about how training centered around biological aspects such as receptor pathways, incidence, genetic risk factors and treatment with anti-psychotics, with little else seeming to be taught apart from some scant allusions to social and cultural factors. The message received from training seemed to be that the dopaminergic-hypothesis of psychosis was the most up-to-date in the field. There was a sense that trainees subscribed to a biological understanding of psychosis overall. This seemed to be about safe, consistent ways of problem solving and assurances for the profession that psychiatrists were not deviating from the status quo.

Pippa: "So ye, my training would teach me that it's excessive dopamine…" (260-261).

Lucy: " ….drummed into me, very much a biological approach…" (202).

A second sub-theme was about ***creativity being reined in***. There were repercussions for developing one's own style, where one would be gently reminded that there is a prescribing protocol or a policy. Psychiatrists seemed to continue to have their mainstream conceptualisation of psychosis consolidated by not hearing alternative ideas. Some psychiatrists rigidly adhered to a bio-reductive conceptualisation of psychosis their whole lives.

Finn "Ye, it doesn't give you that…. I mean, you're qualified to, to be who you are, yet, at the same time, you're getting told to, just rein it in a bit, and not practice your style, or have your style of practice …." (792-795)

The participants described being stuck within a system where there was little tolerance for deviating even slightly from conventional practice and where people were fearful of reducing prescribing. They practiced within a closely scrutinised system, imbued with a fear of litigation, which dampened imagination and

creativity, pushing psychiatrists back on the bed of medical training and orthodoxy.

George: "You know, I imagine, I imagine if you went out and you polled people in the community, and asked them what they make of psychosis you'd get a great richness of ideas about psychosis that most doctors wouldn't even entertain, perhaps because their journey through their medical training or whatever…. If you get medical students who are very early on in their training, one of the things you find is that they very often come up with much more novel ideas about just about everything…because, in a sense, the system hasn't molded and shaped their thinking. The longer they're in the system the more they're under the sway and influence of their training, how they're being sort of trained to critically think about things, you know, how you might address a problem. I often feel eh, that there's something about the training of doctors that's a bit of a hazard to their imagination, something gets lost in the process actually" (286- 309).

Space and Reflection

The theme of ***space and space for reflection*** percolated through the interviews, which was further separated into two sub-themes relating to the ***demands and systems limiting space for reflection*** and ***attitude to models that provide space for reflection*** **(see table 7)**.

Table 74: Themes related to space and space for reflection

Theme	*Sub-themes*	*Source*	
		Accepting	***Critiquing***
Space and space for reflection	***Demands and systems limiting space for reflection***	Iqbal	Ian Lucy Finn George

		James Alice	
	Favourable towards	***Unfavourable towards***	***Both favourable and unfavourable***
Attitude to models that provide space for reflection	James Alice Nilesh Finn	Ian Pippa	Don Lucy Ben

The first sub-theme, about ***demands and systems limiting space for reflection*** related to how little space psychiatrists perceived they got to think. Psychiatrists seemed consumed by the demands of the sheer number of people they must see. As a result, it was challenging to really listen to and consider patients' experiences; opportunities for reflection were rare. This linked back to the earlier ideas about psychiatrists being constrained by the system.

Iqbal: "You don't have time in an inpatient ward or anywhere to go and take down oh, what was happening with that person when they were growing up. You don't do that. It's just not possible. You're dealing with so many things ….. The fact is that there is some genetic link in the family. You don't then go to find out, oh, why was that person presenting as psychotic at that time. Did they have trauma? You don't do that." (183-189)

Models which provide space for reflection, for example the Open Dialogue approach or psychological approaches, were perceived to be a more positive way of getting away from the 'conveyor belt' of the outpatient clinics towards a more multi-disciplinary and holistic approach. On the other hand, they were also deemed to be unrealistic because of the lack of commissioning of these approaches, the lack of time available to engage with them and their expensive nature.

James: "I think psychotherapy has been denigrated in 21st century psychiatry …. I think the resources available to NHS psychiatry, you kind of have to denigrate psychotherapy, because it's a long resource heavy intervention, ehm…and that's true to support staff as much as it is, eh, patients." (1075-1081)

Many of the interviewees spoke about psychology provision or psychology colleagues. Some had great admiration for psychology colleagues. There were also frustrations expressed, with how psychologists would only work with a select few, with how long waiting lists were, and with the use of psychological approaches which did not seem realistic to psychiatrists.

Ben: "So, yes, psychologists, from my point of view, is cherry-picking" (526).

STAGE 5: DESTABILISING THE NARRATIVE

A political critique of the text was directly engaged in for the fifth stage. The *hermeneutic of suspicion* is described by Langdridge as ostensibly political and incorporates engagement with critical social theories. This stage assumes the position that people always speak from somewhere, from some tradition or ideology (Langdridge, 2007).

Imaginative suspicion was cast on the interviews using a *neuro-liberal critique* (Cohen, 2016; Rose, 2007; Warner, 1994). This is developed from the Foucauldian concept of *bio-power*/*bio-politics*, where power exercises itself at the level of life, a way to have control over a population (Foucault, 1976). A *neuro-liberal critique* extends this to see psychiatry as useful to neo-liberalism, a system that equates individual distress with individual pathology, reducible to the level of the neuron.

In doing so, it moves thought away from social, relational and communal explanations for psychosis, locating problems instead in an individual's biology. *Neuro-liberalism* is then enacted as a surreptitious way of restoring privilege to a global ruling elite. For Rose (2007), biological psychiatry is readily accepted as *true*, reinforced by attempts to reduce the biological person to their molecular level, treated by medical intervention at the same molecular level (Rose, 2007). In *neuro-liberalism*, real and powerful hierarchies actively stymie new ways of working and possibilities for conceptualising and working differently. They shape the backbone of prevailing opinion, such that psychiatrists and lay-people construct a world where life is understood fundamentally at a molecular level. These kinds of beliefs not only establish what counts as an explanation, but also establish what there is *to explain* (Rose, 2007). Society then reaches the point where people would "find it difficult to think otherwise" (Rose, 2007, pp.352). This is touched on by Warner (1994) who outlines how anything which counters mainstream orthodox thought gains "little ground in the face of a contrary political and social consensus" (Warner, 1994, pp.131).

There was a sense from the current research that those who aligned themselves with convenient simplifications had found a good way to self-advance and avoid encountering opposition. There appeared to be consequences for threatening the medical dominance in psychiatry and questioning the aspiring scientific status of the profession which holds so much power. The *neuro-liberal* critique suggests that because beliefs about psychosis sit within a political, social consensus holding the ideas in place, then these are the issues that would need to be addressed through a radical politics. The *status quo* could be challenged more by voicing professional uncertainty and sharing vulnerability, even if psychiatrists may subsequently lose their current position of power. Future possibilities could involve emphasising the complexity of psychosis, something which several of the interviewees did (Alice, Finn, James, George, Ben and Don). Another future

possibility could also involve *deliberately* engaging with and seeking the evidence which challenges an exclusive emphasis on bio-reductionism, establishing it alternatively as just a non-hegemonic paradigm. Other possibilities could include greater dialogue with service users, engaging more with reflexivity and rejuvenating that which is suppressed during training.

STAGE 6: CRITICAL SYNTHESIS

Three groups emerged from the research – biological psychiatrists, critical psychiatrists and those more conflicted. Biological psychiatrists were more explanatory in their rhetoric, holding onto their conviction that it was the best way to conceptualise psychosis. Their narratives were professional and canonical rather than personal. There was evidence of their ready acceptance of what they were taught on training or read in textbooks. They considered their roles to be related to diagnosis, management and medication. They were also less likely to have had exposure to alternative ways of thinking or if they had, they had not adopted them. Even those who recognised the impact of trauma in some instances still identified as biological psychiatrists in the main. They spoke much less than their counterparts about psychological or social factors and none seemed to have heard of the BPS/DCP document or the CPN. Overall, they recognised very few contested areas in psychosis. Those that they did identify were mainly related to diagnosis.

A middle group were those less certain in their position, who still seemed to be open to shaping their views by attending conferences, speaking to colleagues with different ideas and reflecting on their own experiences. They were more likely to hold on to multiple perspectives and identify themselves as still learning, discovering, questioning and exercising curiosity. They shared more narratives about the self and the tone of their narratives was overall, more reflective. They

were less aligned with any one way of understanding psychosis and recognised more contentious areas including the lack of certainty about the etiology of psychosis, limited incorporation of spirituality, the social impact of psychosis and possible collusion between pharmaceutical companies and psychiatry. One of them had both seen the BPS/DCP document and been to a talk given by a prominent member of the CPN.

The third group was more critical in their thinking and three of them were familiar with the CPN or were active members. They were more outspoken about contested areas which centered around how traditional psychiatry was potentially harmful or damaging to people. They spoke about the lack of progress within the profession and about how hierarchy and authority worked to perpetuate a bio-medical framework of understanding psychosis. The critical group saw conventional orthodoxy as unhelpful and simplistic. They were more likely to have had exposure to advocacy groups and service-user movements, and to consider research and academic psychiatry as biased towards bio-reductionism which was having little positive impact in their view, on patients. They were an even more reflective group who shared more narratives about themselves and their backgrounds, values and beliefs and how this influenced their engagement with psychosis. They were also more familiar with and valued models of working based on psychodynamic, dialogical and systemic (e.g. Open Dialogue) or social science theory compared to biological psychiatrists.

The participants generally felt that psychiatrists were disempowered to exercise positive change in the system in which they worked. They felt scrutinised and under pressure to conform and adhere to orthodox practices and populism. Not doing so was to risk admonishment. There was a sense that alternative or critical ideas were not encouraged, or were kept on the periphery by mainstream biological psychiatry. The hermeneutic of *neuro-liberalism* would hypothesise that

this relates to the presence of a political and social consensus that life should be defined and explained at a molecular level. Locating problems in an individual's biology serves to move thought away from social, relational and communal explanations for psychosis. People in senior posts within the profession were "experts" with the answers, seemed to have great power and were perceived by the critical psychiatrists as working to sustain orthodoxy. Those perceived as having status and power in the profession were more likely to be biological psychiatrists and there was a sense that questioning bio-medical psychiatrists, who were accepted as having more power, might be perceived as audacious or risky. In training, they kept the focus predominantly on neurobiology, diagnosis and medications, with trainees seeming to readily accept the idea that the dopaminergic theory of psychosis was still the most up to date.

As a profession, participants felt they had little space or time to reflect and show or share vulnerability. There was some evidence of negative views towards those who might use more reflective models of working. This seemed to lend itself to a culture of conveying *in*vulnerability and identifying with populist idea about being the doctor, the expert and orchestrator of action. They spoke of a lack of time to engage with other models, for example, those which might be informed by psychological theory. There was a perception that these kinds of models were not commissioned, and were too expensive and time-consuming.

DISCUSSION

The aim of the current research was to elicit narrative accounts of psychiatrists' positions on psychosis and to identify any contested areas considering the BPS/DCP document "*Understanding Psychosis and Schizophrenia".* Recruitment

took place across three NHS Trusts. A broad range of views were sought from trainee to consultant level. Narratives were analysed along with the attendant tone and rhetorical function. The hermeneutic circle of Critical Narrative Analysis developed by Langdridge (2007) was used.

The main findings are interpreted and related to both theory and practice and limitations are considered.

Power

Power in the current study exercised itself through an established hierarchy. Senior figures in the profession, more likely to be bio-psychiatrists were considered experts whose views dominated. Their position appeared throughout the interviews to influence training, where identification with bio-reductionism was promoted and more creative ways of thinking were allowed to wither. Within this culture, participants sometimes felt compelled into conforming with mainstream psychiatric practice or, as a way to cope, adopted the idea that they were impossibly constrained by it so were limited in their capacity to exercise change, though of course there are those trying to effect change through such things as the *Critical Psychiatry Network*. Many of the participants' narratives touched upon how they were coerced by demands and pressures which took them away from opportunities to engage with other ideas.

Nevertheless, compared to their patients, psychiatrists clearly occupy a significantly more powerful position (McCubbin & Cohen, 1996). Their power is both visible and invisible (Bracken & Thomas, 2001; Cutcliffe & Happell, 2009). It has been contested that power structures in psychiatry are maintained partly for political reasons, where it is more convenient to attribute mental distress as

stemming from biological rather than social factors (Johnstone, 2000). Cohen (2016) argues that the more useful psychiatry is to the neo-liberal system, the more power it gains from it keeping the focus away from community, organisations and society. This has been described elsewhere as pharmaceutical companies and psychiatry entering into a "storytelling partnership" (Whitaker, 2002, pp.303). A bio-reductive framework of understanding psychosis potentially reinforces psychiatry's position of power, something which might be understandably difficult to forgo, because of the pre-eminence and influence that comes with it (Friedson, 2001; Moreell, 2010).

Although psychiatry as a whole has considerable power, the individual psychiatrist will have less capacity to effect change. Nevertheless, perhaps in positioning themselves as *powerless*, they may try to absolve themselves of responsibility, distancing themselves from the collusion which conformity bestows. Some members of the profession may also be avoiding the possible consequences of holding on to other ideas or sharing uncertainty or vulnerability, such as having their power threatened or undermined (Politi & Legare, 2010).

DIALOGUE

The current research highlighted the diverging, sometimes polarising views held within in the same profession. What stood out from the research was the lack of exposure that some psychiatrists had to views which contrasted with their own. They themselves identified a lack of opportunity to talk. It appeared that participants were gravitating towards those who agreed with them. Only two of the twelve participants had read the BPS/DCP document and only four had heard of the *Critical Psychiatry Network*. Dialogue was also impacted by hierarchy and perception of expertise within the profession. There was mixed evidence of

valuing dialogue and input from MDT colleagues such as clinical psychologists, whose therapeutic work or ideas appeared at times to inspire criticism rather than alliance.

The current research suggests that both biological and more critical psychiatrists gravitate towards those who share the same opinion as them. It is common for people to stay connected with those who hold similar views, gradually loosening ties with those who think differently, a psycho-social tendency known as homophily (McPherson *et al.,* 2001). The Royal College of Psychiatry expects all psychiatrists to join a peer group as part of their continuing professional development, but they are "free to choose their own peer group" (Royal College of Psychiatry, 2015, pp.3). As a result, it is likely that the different groups identified in the current research will have few opportunities in a peer group setting to hear alternative views to their own.

Even with greater opportunities for dialogue, it can also be extremely difficult to encourage alternative perspectives with information alone (Lord *et al.,* 1979). The "*mere availability of contradictory evidence rarely seems sufficient to cause us to abandon our prior beliefs or theories*" (Lord, 1979, pp.2108). Strongly held beliefs can survive being challenged, something which may partly explain frustrations by members of the *Critical Psychiatry Network* at what they perceive as the Royal College of Psychiatry's reluctance or complacency about debate or even discussion (Moncrieff, 2013; Thomas, 2014).

It may be important therefore, to inspire shifts in perspective, for dialogue to be accompanied by *curiosity*. There is some evidence that open-mindedness and curiosity draws people towards information which contradicts their existing beliefs and can see them on the path to changing their minds (Kahan *et al.,* 2016). Open-mindedness and curiosity have already been adopted in systemic ways of

working (Cecchin, 1987). A curious stance towards the many different opportunities for dialogue that are available, such as specialist interest groups within the Royal College of Psychiatry, organisations such as The International Society for Psychological and Social and Causes of Psychosis, multi-disciplinary-teams and Service-User led organisations may facilitate wider learning and understanding.

Reflexivity

Participants who identified as biological psychiatrists generally had narratives that were more explanatory with interviews, on average shorter than those who were more critical. One possible explanation is that less time is needed to offer a more straightforward understanding of psychosis, that it is reducible to underlying biology. In contrast, it takes more time to tell stories that require reflexivity and engagement with uncertainty and nuances. A lot of interviewees spoke spontaneously about their own life and inner self, something which was not anticipated before the interviews were undertaken. The person brought into the interviews, in the form of identity construction often related to how they understood and engaged with psychosis as a contested area, for example through faith or spirituality.

This posed the question of the effect of introducing reflective practice more fully into psychiatry. Currently, models of supervision in psychiatry at trainee level are often described as educational, where supervisors are allotted to oversee learning plans, goals for training and to provide feedback (Royal College of Psychiatry, 2010). Mohtashemi *et al*. (2016) found that psychiatrists identified numerous barriers to reflexivity including a lack of time, feeling under enormous pressure to reach quick decisions and to conform to the bio-medical model. Another barrier

to reflexivity is hierarchy. The psychiatrist Bekas (2013) speaks about the exceptionally hierarchical structure trainees are often faced with in medicine which even permeates reflective practice, where reflections from those in a higher status are considered more valuable: "*rules and chunks of knowledge from the "old timers" are promoted as the initiating steps to acquire legitimacy in this community*" (Bekas, 2013, pp.322). One of the barriers to reflexivity identified in the current research also appeared to relate to the attitude of psychiatrists to psychology, a profession more associated with working with uncertainty, pluralism and use of reflective formulations in teams (BPS, 2011). There were several criticisms of psychology in the current research which included frustrations with waiting lists, and the suggestion that certain types of psychologists were valued over others and that those associated with the BPS/DCP document served to spark even further inter-professional rivalry. However, with greater reflexivity, there may be the potential for new understandings to emerge (Schon, 1984).

In the current research, more critical leaning psychiatrists were observed to have thought about and analysed their own actions and explored their own experience, creating new personal meaning and even bringing about a change in perception, something promoted by proponents of reflexivity (Boyd & Fales, 1983; Stedmon & Dallos, 2009). Engaging with reflexivity can invite doubt and ambiguity and the questioning of implicit knowledge and assumptions; this contrasts with striving to be objective, rational and unreflective. Encouraging more reflexivity has the potential to disrupt habitual and rigid styles of behaving and thinking (Habermas, 1971). Freire (1971) would say that critical reflection ("concientization") can be liberating. In his concept of *praxis,* he suggests that it is not enough to just enter dialogue and talk, but that transformative action is required too. In this way, reflexivity, as a social function has the capability to revolutionise group-established practices and even society. Of course, reflexivity, like talking, also requires curiosity.

LIMITATIONS

One of the limitations of the current research is that it does not represent the views of all psychiatrists, so interpretation of results is taken with caution. The advantage of course of fewer, more detailed interviews is that it affords a much richer understanding of experience. Although the researcher deliberately sought differing perspectives across three different Trusts, it is possible that participants approached would have been more likely to agree to participate if they felt more sympathetic to the topic. The results could therefore be skewed in this manner.

A second limitation is that the researcher's background and training may have influenced how the participants engaged and how she focused on the data and indeed the conclusions she drew.

A third limitation is brought forward by Silverman (2006) which is that the researcher could have underestimated how much the narratives elicited were impression-managed, narratives which obscured contradictions, inconsistencies or uncertainties. This does not necessarily invalidate the narratives which were usually recognisable and clearly defined (Chase, 2008).

A fourth limitation related to the significant challenge of both viewing the group wholly, whilst not foregoing the subtleties of each participant. Langdridge (2007) describes CNA as particularly demanding, an approach that can be regarded as an ambitious and time-consuming form of analysis, with most previous CNA studies mainly being single case studies. To apply this method to a sample of 12 was obviously even more challenging again and may prompt speculation that a less complicated analytical approach would have sufficed. It has potentially offered interesting material which may not have been unveiled using other approaches

and there are recent examples of the use of CNA to larger samples (Stacey *et al.,* 2016, Ling & Kasket, 2016).

Conclusion

This research identified three groups within a group comprised of trainee and qualified psychiatrists. The first group were biological psychiatrists who recognised few contested areas in psychosis and had little exposure to alternative ways of thinking. A second group were less certain in their thinking, still having their views shaped. They recognised more areas of contention. A third group were more critical of conventional orthodox practices in psychiatry. They had more exposure to advocacy groups and were more personally reflective. The themes identified in the research pointed to a feeling of disempowerment to exercise change amongst psychiatrists who felt that identifying with bio-reductiveness was promoted from training level upwards. A culture of invulnerability was created in the profession, reinforced by a strongly held position of power by some within the it. Psychiatrist's experience of power and how it acts as a barrier to change could be an avenue of future research. The BPS/DCP document "*Understanding Psychosis and Schizophrenia*" promoted valuing divergence of perspectives. The current research suggested that some psychiatrists had few opportunities to engage with alternative views or to talk to others. A curious stance, combined with greater opportunities for reflective practice may facilitate wider learning and understanding of multiple ways to understand psychosis. These could be avenues of future research.

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PART III: CRITICAL APPRAISAL

The critical appraisal is based on a diary I kept throughout the research process where decisions, dilemmas and limitations were noted. It will consider the strengths and weaknesses of the research and also how it developed my research skills. This appraisal will address the most salient themes from this diary, rather than an exhaustive chronology.

CHOICE OF TOPIC

I had a background in psychosis-related research, having been at the Psychosis Research Group at Trinity College Dublin previously. So, at Leicester, seeing Richard Bentall at the research conference for the out-going cohort in September 2014 reminded me why research in this area is so interesting. The first set of teaching on psychosis was quite early on in the course, in October 2014. It was facilitated by two members of the core staff team, including the supervisor of the current research. Their teaching focused on a broad overview of the whole area as well as developing a psychological understanding of psychosis, and I found it really interesting. I first came across the BPS/DCP document itself in January 2015 when someone in my cohort emailed it around to the rest of us. She had come across it on her placement and she thought we would find it useful. My interest in doing research related to this area by now was truly piqued. By the time I was in the stages of developing a project, there was an opportunity during my first year placement to attend a "Psychosis Interest Group" comprised of clinical psychologists working in adult services where I was on placement. They specifically discussed the document, prompting discussion about working psychologically with psychosis and how to follow up some of the recommendations from the report in their own teams. It was a really stimulating meeting and they were also notably inclusive of trainees, which contributed to my experience of it as positive. I was excited about a research project that genuinely captivated me, rather than something I had little enthusiasm for which I might tire

of or even resent. I was of course anxious about undertaking a qualitative research project, something I had never done before, particularly in an area as vast as psychosis and I worried that qualitative research required a kind of poise and experience that I lacked.

CHANGES TO ETHICS APPROVAL PROCESS

One of the first dilemmas was something which impacted my whole cohort. In 2016, the Health Research Authority (HRA) became the main process for applying for research approvals, a change that meant that applications for research would automatically go to a Research Ethics Committee. The benefit of this is that since March 2016, HRA replaced the need for a National Health Service Research and Development form. For my cohort, it meant navigating a new system whilst it was being rolled out nationally. At times, it was somewhat confusing about what was still under the system being moved out and what was under the new system being implemented. Overall, it was a valuable learning experience and I tried to treat every hurdle as an opportunity to develop my research skills. The two additional Trusts I sought approval for intermittently sought updates and this was a useful prompt for myself to reflect on how the research was progressing. Having three Trusts to recruit from meant that I could maintain an optimism about securing participants because there was a much greater pool to select from even at times when I was struggling to recruit. It worked out that at times when recruitment dipped, that I could turn my attention to transcribing or the literature review. It became therefore a valuable lesson in the advantage of working flexibly but always working on something.

INTERVIEWS

One of the interesting aspects of the research to me, was how long the interviews lasted. Often, prior to the interviews, participants said that they had a certain window of time, sometimes as little as 45 minutes. Yet, once engaged in the interview, participants would often run over time and, when asked how they were doing for time, would say that they were keen to continue, indicating that what they had to attend to next was now less urgent. The length of the interviews relative to how long people initially had to give to them was not something I, or indeed the interviewees themselves had anticipated. Of course, longer interviews meant considerably extra transcribing. Yet from my perspective, if I limited the interviews I would not gather consistent kinds of information across the different perspectives. In that respect, I do not regret that the interviews were longer and I think it was ultimately worthwhile because richer, more interesting data was gathered. I was also very conscious of how important it was to hear what people had to say, particularly as establishing rapport and making people feel understood seemed important during the interviews and there were certainly times it would have appeared abrupt or rude on my part to hurry participants or cut them short, particularly when they were electing to share details of personal experiences. I was certainly surprised by how personal the interviews became as they went on. I think this was partly because I learned that it was more appropriate to ask people questions relating to identity *after* rapport had been established and the interview had entered a more comfortable phase. Although I was still trying to ask everyone the same kinds of questions, I started to ask them differently and at different stages of the interview.

My thoughts were that the prolonged interviews were also in part due to the complexity of this area and how you cannot incorporate all its intricacies into a pre-determined time-frame. It taught me that in talking about this topic, the

conflicting parts truly emerge, particularly for more uncertain or critical psychiatrists. By the last few interviews, I was so interested in why the interviews were running on for so long that I asked the last three participants why *they* thought this was, to see how it compared to my own ideas. James said that "you've given people the opportunity to talk" about "difficult to answer, impossible to answer, or bizarre situations…moral quandaries, emotional challenges, philosophical weirdness" (1065-1066). Another participant, Alice, commented on my role in the interview saying that she had felt understood, that she could tell I was "authentically curious" (1018) and had picked up on threads and made her think about things. This was an interesting idea and has made me think since about the complex interplay between the opportunity the interview naturally gave people to make reflections and my part too in this because of my own, at times, insatiable curiosity.

THE DESIGN AND METHOD OF ANALYSIS

During the application of Langdridge's hermeneutic circle, I found it very challenging, as expected, to work with such a large amount of data and to attend to the group yet not lose the individual stories. I undertook twelve interviews to get a broad range of responses to capture the diversity of opinion in the profession. The advantage of this was that the larger number meant that more common central themes could be uncovered and that variations or diverse views could be accessed. The disadvantage of the larger sample meant that individual narratives could not be attended to in the same depth. For this reason, I think I found the second and sixth stages of the analysis the most challenging because it involved condensing and coalescing across twelve people. I was loath to abandon interesting narratives or to have to decide which ones were the most salient and which ones although at times fascinating, were less relevant to the topic. Although transcribing was without doubt very time-consuming and laborious I was so

protective of the interviews I did not want anyone else to transcribe them. In undertaking this research project, I had no choice but to meet sometimes punitive deadlines I set myself and develop confidence in putting forward my ideas, even if at times, this felt quite exposing.

Darren Langdridge has stated that Critical Narrative Analysis (CNA) is a particularly demanding method and that was in the context of applying the hermeneutic circle to one participant (Langdridge, 2007). This was something I knew well in advance of commencing the analysis and is something which has been reiterated by others who have used the approach (Ling & Kasket, 2016; Mair, 2010). Langdridge advocates for the method being adapted to suit individual projects, for example, omitting the first and sixth stages or merging stages two and three. Although it was complicated I learned that CNA is an enlightening method and was very suitable to my research topic. Advantages of the methodology was that it represented rich and detailed data from multiple perspectives and these perspectives were conserved throughout the process. Its appeal is its foundations in phenomenology, its attendance to aspects of narratives including tone and rhetorical function and how it applies a *hermeneutic of suspicion.*

To me, CNA, as a method, fits quite well with practices in clinical psychology, particularly the value placed on reflecting on-the-self (Lavender, 2003) and developing self-awareness (British Psychological Society, 2008). A second way that this method fits with clinical psychology relates to the pluralistic approach of the profession, that ability to draw on a wide range of ideas in circulation. As trainees, we become familiar with not having to have any fixed allegiance to any one approach, and particularly by third year, are encouraged to integrate different ideas. This research allowed me to further develop my skills in working within a pluralistic framework, holding on to multiple perspectives, complexity and the idea of there being room for other possibilities. Langdridge himself put me in

touch with a psychotherapist, David Mair now Head of the Counselling Service at the University of Birmingham who had, under his supervision used the CNA approach (Mair, 2010). Mair kindly sent me a copy of his thesis. I discovered separately that a researcher, Jeanne Ling had used the CNA approach for her doctorate in counselling psychology at the London Metropolitan University and I purchased her full dissertation through the British Library EThOS service (http://ethos.bl.uk). She had applied the approach to a sample of six, comprised of three couples and I thought her use of CNA was well done. It remained on my desk throughout the analysis and write-up stages, to signify to myself "this is possible," particularly as she had gone on to publish her work (Ling & Kasket, 2016).

Of course, alternative methods of analysis might have led to other findings. One such alternative is grounded theory (Charmaz, 2014). This is a method that would have tried to construct a theory grounded in the data following constant comparative methods of analysis and category development. One of the main ways this would have differed from CNA is the use of coding and raising of analytical questions early on. This method would have allowed for gaps to be filled through further data gathering. Grounded theory has a more positivist epistemological underpinning compared to CNA as it places more emphasis on scientific methods. Shifting the epistemological position and using this method as an alternative might have allowed for earlier analysis and potentially, a theory from the data. A second alternative method of analysis might have been critical discourse analysis (Fairclough, 2013) which brings social theory and linguistic analysis together, exploring the relationship between discourse and other social factors such as power, ideology and institutions. This method would have emphasised more the relationship between dialogue and socio-political context, whilst also looking at rhetoric. The stages it would have adopted would have been more so the analysis of spoken language, the analysis of discourse practice and

analysis of socio-cultural practice (Fairclough, 2013). Putting greater emphasis on a positivist, scientific method might also have been possible, though to me, a statistical analysis of the interviews seems both ludicrous and rather pointless. The research question was, in my opinion, best answered using a qualitative methodology. The data is not compatible with statistical analysis and so it remains objectively unverifiable.

For the fifth stage, in applying the hermeneutic of suspicion, alternative choices of critical social theory could also have been used. Further research could be undertaken where a different choice of social theory is applied. Langridge suggests six hermeneutics of suspicion including gender, class, race, ethnicity and disability analysis, amongst others. It would be interesting to apply other critical social theories. One critical social theory which might fit well includes *theory of reasoned action* (Fishbein & Ajzen, 1975) or Moos's *social context perspective* which explores social contexts and how individuals influence each other (Moos, 2003). There are probably other critical social theories which could have been used also. There is lack of clarity about how much self-reflexivity should be applied to one's choice of social theory. I think that my choice of *neuro-liberalism* was partly influenced by the community psychology module on our training course where I have been learning about how to consider wider contextual factors. I wanted to use a hermeneutic that embraced factors related to power and the role of power in context, in this case, how power exercises itself at the level of life, used as a political object. The benefits of the *neuro-liberal* critique were that it looked beyond the *status-quo*, casting suspicion on the system that psychiatry inhabits, a system that extols individualism and expands the power of psychiatry. The hermeneutic attempted to unpack the growing power of biological psychiatry, looking beyond the individual to society and organisations, and in doing so, denoting the kind of level at which social change might occur.

PSYCHOLOGY & PSYCHIATRY

One of the dilemmas of the current research project was what it would mean for relations between clinical psychology and psychiatry. I was aware that following the BPS/DCP report in 2014, that a prominent member of the Critical Psychiatry Network, Phil Thomas, had criticised the report for omitting and under-including the perspective of people from Black or Ethnic Minority (BME) groups. He commented that clinical psychologists themselves were also as badly affected by flawed thinking about psychosis as are those who use biomedical diagnosis and practices, something he described as sadly ironic (Thomas, 2014). Some psychologists involved in the report drew his attention to sections in the report relating to the experience of psychosis in ethnic minority groups and the discussion of the impact of discrimination. A criticism could be that I too did not expressly ask participants about psychosis from a BME perspective, the reason being that I was leaving it open to participants to decide what areas of contestation they identified themselves. It leads me to wonder if my research might enter the uncomfortable territory of inter-professional rivalry that seems to exist sometimes between clinical psychologists and psychiatrists. It also leads me to wonder how quickly any shortcomings within my own research would be quickly announced; it is, after all imperfect and I may even be unaware of some of its limitations, not least because I am a novice qualitative researcher. As a very junior member of the clinical psychology community, I wonder too if I might become conflated with those perceived by psychiatry as more ardent, public critics of psychiatry, much like how Don described how the Critical Psychiatry Network is often conflated with some anti-psychiatrists. I hope that I have incorporated psychiatrists' *own* stories and their *own* perspectives, rather than suppositions or speculative summations inspired by how one might negatively stereotype psychiatric practice.

During the research, admittedly, it was hard not to feel defensive at times about the numerous criticisms of psychology or how psychologists were outlined by some participants. It was difficult not to be swayed more towards becoming critical in my position. I have tried as much as I can to uphold a position of curiosity about a range of perspectives, something which was quite challenging at times given my own biases. I may have been even blind to my own biases stemming from having thoughts and feelings in response to participants which were ambiguous (Chenail, 2011). My reaction to criticisms about psychology, particularly met with my own pre-conceptions and views around psychosis at times challenged my curiosity and risked biasing the analysis in favour of more critical positions. I tried to overcome this by making genuine attempts to be upfront about my own biases and to appreciate the vulnerability of participants. Considering how the CNA method requires of the researcher overt use of reflective engagement, I had to bring my attention to how my own assumptions, pre-conceptions and biases could impact. I perhaps fell victim at times myself to the very psychological tendencies I spoke of in the discussion, particularly confirmation bias and homophily. I strove to limit and manage my own biases in several ways. As previously mentioned, I kept a reflective diary throughout the research process, particularly noting my thoughts and reactions to each individual interviewee and what they had said. I returned to data again and again, particularly noting where I had to invite myself to be more curious. I also used research supervision to think about my own biases, where they might be coming from and how I could restrict them. I had many conversations with others, particularly qualified psychologists and peers. It was useful in this respect to talk with those who were not involved in psychosis related research as they were more neutral.

CONCLUSION

This critical appraisal is based on a reflective diary kept over the course of the research process where I have outlined the main dilemmas, challenges and limitations. I have thought about why the interviews were often lengthy and how this was probably a mixture of how this topic elicits complexity represented in narrative, language and reflexivity, in combination with my own curiosity and style of interviewing. I have considered the advantages and limitations of the research design. Critical Narrative Analysis is a particularly demanding method and I drew inspiration from those who had also used this approach. It is a method rooted in phenomenology and its appeal is its attendance to narratives, tone, rhetorical function and the use of a hermeneutic of suspicion. Its attendance to reflecting on the self and self-awareness in addition to how it holds on to other possibilities and perspectives ties in, in my opinion, with clinical psychology. There are limitations to this research. It is not generalisable, or objectively unverifiable. Alternative methods of analysis or hermeneutics of suspicion would have led to different findings. It has been a challenge to restrain my own biases, and endeavor to be less critical and I had to employ several strategies to try to overcome these. Despite these shortcomings, the current research represented diverging perspectives in psychiatry, from biological to critical psychiatrists. It highlighted the role of power in the profession and the culture this generates, with implications for engagement in increased dialogue and reflective practice.

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PART IV APPENDICES

APPENDIX A

APPROACH AND EPISTEMOLOGICAL POSITION

Unlike other methods which could have been used, Critical Narrative Analysis (CNA) was selected, which looks at narratives and how these narratives connect to wider contexts. A key characteristic therefore of CNA was the inclusion of a *critical moment*, using social theory and a *hermeneutic of suspicion* (Langdridge, 2007).

The research instrument used, the interview, did not have validity measures available. Rather, in accordance with Anney (2014) *confidence* replaced validity, *credibility* replaced internal validity, *transferability* replaced external validity and *confirmability* replaced objectivity. The study was considered *credible* because the research questions were deemed to be of interest and value, considering the BPS/DCP report and the presence of the *Critical Psychiatry Network* within the profession and both their positions on psychosis as a contested area. It was considered *original* because it was not a duplication of any similar qualitative research study and it was believed to be *transferable* to both the psychology and psychiatry professions as our understanding and treatment of psychosis evolves.

There are of course assumptions which implicitly determined the research methodology chosen for this study. The epistemology was *dialogical-contextual-constructionist*. It was contextual-constructionist in the sense that it assumed that knowledge can be constructed in the interaction between people, through language and narratives, developed and transmitted within cultural, systems and social contexts (Crotty, 1998). It was dialogical whereby all meaning assumes a *reciprocating other*, conceptualised as *answerability*. One's own understanding

cannot occur without *other or others* (Pearce, 1994). This is exemplified by this quote from Bakhtin "*my voice can mean, but only with others – at times in chorus, at best in dialogue*" (Clark and Holquist, 1984, pp.12) where imagined audiences impact emerging narratives. This meant for the analysis that there was going to be a central recognition that people would be speaking within the context of the *reciprocating presence of the other*. This informed the interviews undertaken in that the researcher had to attend to whether they were the addressee or whether the addressee was someone outside the interview and for this to inform part of the analysis. Central to Bakhtinian theory was that what is said is often said with anticipation to how another *might respond*. The researcher, though she would inevitably speak less than the interviewees, was aware that any utterance on her part might have had consequences for the dialogue and would reflect both the pre-conceptions and biases she had already consciously reflected on, but also those in the moment, which she may implicitly have communicated through any utterance. Dialogics assumes that there was no abstract addressee, the addressees in the research were anticipated to be anyone who was a member of the same group, or anyone not a member of the same group.

Similarly, the researcher, in engaging in the analysis and writing it up, also had her own addressee in mind, someone to whom she was communicating to. Here, the "addressee," may be presumed to be an academic audience, those who may critique or question the research, to whom the work is justified to, those perhaps with a certain familiarity with or interest in the topic, with the intention that the research may also elicit further discourse, counter-argument and debate by those who were addressed. The researcher allowed for simultaneous addressees, potentially clinical psychologists, psychiatrists, peers, people with experience of psychosis, various opponents and assumed allies (Pearce, 1994). The Bakhtinian perspective is also replete with the role of power. One of the reasons tone was attended to in the analysis used was because this betrayed whom the speaker

imagined they were addressing, and it was this which was going to reveal any power dynamic. The relation to the speaker was inferred from observing the pattern of dialogue. This is likened to how a telephone call necessitates the presence of someone on the other end (Pearce, 1994). Resultantly, the method approached both the interviews and the analysis as profoundly interdependent views of human communication. Finally, part of the CNA analysis drew on Bakhtin's study of Dostoevsky's writings, and how connections commence after the ordinary plot had drawn to a close (Kim, 2016). This led to attending to other possibilities in the analysis, as such, the plot was not fixed or conceived as the only possible story.

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APPENDIX B

LETTER OF ETHICS APPROVAL

NHS
Health Research Authority
[redacted] Research Ethics Committee
[redacted]

24 February 2016

Dr Therese O' Donoghue
Trainee Clinical Psychologist
Leicestershire Partnership Trust
School of Clinical Psychology
University of Leicester
104 Regent Road
LEI 7LT

Dear Dr O' Donoghue

Study title:	**Critical thinking and psychiatric knowledge: how trainee and qualified psychiatrists understand and engage with psychosis as a contested area.**
REC reference:	**16/WM/0110**
IRAS project ID:	**195842**

The Proportionate Review Sub-committee of the [redacted] Research Ethics Committee reviewed the above application on 24 February 2016.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC [redacted]

[redacted]

Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Ethical opinion

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

APPENDIX C

COURSE OF THE RESEARCH

January 2015	Research proposal preference form submitted Research supervisor allocated
February- March 2015	Consultation with research supervisor – ideas considered
April-May 2015	Met with senior lecturer at De Montfort regarding potential research project (subsequently abandoned this idea) Developed initial research proposal
June 2015	Panel feedback for research proposal at University of Leicester
June– December 2015	Developing research proposal Lay response from Service User Reference Group received back Sponsorship by employing Trust agreed Submitted research proposal for peer review to university IRAS (electronic), prepared and submitted
February 2016	Ethics granted 24th February 2016
March 2016	x1 interview
April 2016	Transcribing commences
May 2016	x2 interviews Submitted application to conduct research at 2nd site, approval granted Bracketing interview completed Transcribing

June 2016	x2 interviews Submitted application to conduct research at 3rd site, approval granted Transcribing
July 2016	x3 interviews Transcribing
August – October 2016	Literature Review Transcribing
November 2016	x3 interviews Transcribing Literature Review
December 2016	Transcribing Literature Review
January – April 2017	Analysis and writing up period Sent yearly update on study to Research Ethics Committee
April 2017	Submission of thesis to University of Leicester (deadline 28th April)

APPENDIX D

PARTICIPANT INFORMATION AND CONSENT FORM

School of Psychology Clinical Section University of Leicester Centre for Medicine
Lancaster Road Leicester LE1 7HA
Tel: +44(0) 116 223 1639
Fax:+ 44(0) 116 223 1650

A study into how trainee and qualified psychiatrists understand and engage with psychosis as a contested area.

Purpose of the study

In 2014, the British Psychological Society and the Division of Clinical Psychology published a report *Understanding Psychosis and Schizophrenia*. Although the report was widely circulated and received a good deal of publicity, it represented the views of the contributing members of the DCP and largely reflected the viewpoints of clinical psychologist working for the NHS or universities. This report contested the view among large sections of the psychiatric community that psychosis is biological in origin, that conditions are generally attributable to hypothetical chemical imbalances and medications are subsequently promoted for their ability to correct such assumed abnormal biochemical states. The proposed research would attempt to explore an under-researched topic where there is a clear gap in knowledge: there is no published qualitative research, which explores the subjective experience of psychiatrists and trainee psychiatrists in relation to psychosis as a contested area.

Participant involvement

Participation will involve a single semi-structured interview lasting approximately 45-60 minutes which will be audio-taped and transcribed for analysis. Themes covered in the interview will involve:

- Working with psychosis

-The etiology of psychosis and where this understanding comes from

-Engaging with psychosis as a contested area and what areas (if any) are contested

-The Critical Psychiatry Network and their viewpoint

-Discussion will also involve reflection on the participants' beliefs and values, and how they may influence the participants' approach to clinical work.

Inclusion criteria

Participants must be trainee or qualified psychiatrists employed by the NHS in the [redacted] deanery.

-Participants must have worked in a service which caters for persons with experience of psychosis for at least six months

-Participants must have understood what the study is about and what their participation will involve

-Participants must have provided informed consent based on this.

Confidentiality and anonymity

Every effort will be made to ensure that identity of participants will be anonymised throughout the research process. Any identifying information will be excluded from transcripts. Tapes will be stored securely and wiped after successful completion of the study or upon participant withdrawal. A copy of the tape will be available to you upon request.

School of Clinical Psychology, University of Leicester

Centre for Medicine

Lancaster Road

Leicester LE1 7HA

		Please initial each box
1	I have read the participant information sheet and understand this research.	☐
2	I have had the nature of the research explained to me, and have had the opportunity to ask questions and discuss the study and have had these questions answered satisfactorily.	☐
3	I understand that participation will consist of a single semi-structured interview, which will be audio-taped. I understand that in the event that transcription should occur through an employed individual other than the chief investigator that the individuals handling raw data will respect anonymity and confidentiality.	☐
4	I understand that my participation is voluntary and I may withdraw from the study at any time without justification.	☐

5 I understand that all information will be treated confidentially and that tapes will be wiped upon successful completion of the study or upon my withdrawal from the study. ☐

6 I understand that all information relating to the interview conducted will be stored securely. ☐

7 I agree to take part in this study, as laid out in the participant information sheet. ☐

8 I agree to be interviewed and for the interview to be audio-taped and transcribed. ☐

9 I agree to take part in the above study. ☐

Participant Name (BLOCK CAPITALS) _____

Participant Signature_____

Date_____

Chief Investigator (BLOCK CAPITALS)_____

Signature_____

Date_____

APPENDIX E

INTERVIEW GUIDE

1. Introduction

a. Personal introduction

b. Outline the research

c. Consent and confidentiality

d. Acquiring information on identity e.g. gender, ethnicity, cultural identity, age etc.

2. **Experience/roles**

a. How long working/client types/settings

b. Case load with psychosis

c. Theoretical orientation during psychiatric training regarding psychosis

3**. BPS/DCP Document**

a. Familiarity with

b. Reaction within psychiatric profession (if applicable)

c. Personal reaction (if applicable)

4. **Beliefs around psychosis**

a. How would describe own beliefs about psychosis

b. Where did these beliefs stem from

c. How these beliefs influence work

d. Examples of this

e. How does practice influence beliefs

5. **Psychosis as a contentious area**

a. Are there any contentious areas

b. Why might psychosis be contested

c. What does it mean for you/the profession

d. How does this shape beliefs/practice

e. How about colleagues

f. How about service users

6. **Critical Psychiatry Network**

a. Familiarity with/membership of

b. Relationship with this network

c. Experience of colleagues who might be/not be members (if applicable)

d. Influence on the profession/practice

7. **Ending**

a. Review consent covered

b. How has the interview seemed

c. Anything to add that hasn't been covered

APPENDIX F

EXTRACTS FROM BRACKETING INTERVIEW

Jon: Partly the value is in you doing this and then thinking about it. What, well first of all, were you surprised by what you wrote down? Or was this very much what you were expecting?

Therese: I don't think I was surprised by what I wrote. I think something that did surprise me was that in the end I decided that a lot of my knowledge, and a lot of my views don't really come from clinical work, cause I have had, pretty much no experience of working with people with experience of psychosis.

Jon: Mm.

Therese: Okay. So, it made me think a bit – so, where do they come from, where do these ideas come from.

Jon: Okay. So, they don't come as much from ehm, cause you start off talking about undergraduate –

Therese: Ye.

…….

Therese: I never knew about really, how critical the monozygotic twin studies were.

Jon: Right.

Therese: Because when I was in research -

Jon: Mm.

Therese: That was held up as the hallmark for where the evidence for -

Jon: Ye

Therese: Why the - where the rationale for genetic research comes from.

Jon: Mm

Therese: I was sitting there thinking – I wouldn't have thought of it like that.

Jon: Okay.

Therese: That's held up by the World Health Organisation.

Jon: Mm

Therese: It's always the first line in so many …. everywhere you read that. So, that's where, I was surprised to hear that. So, that's back….so in the end, I went on to talk about experiences of supervision, so where, em -

Jon: Mm

Therese: Where I don't have experience of working with psychosis.

Jon: Ye

Therese: And that's such a shame, and then I was as saying I had a supervisor -

Jon: Ye

Therese: Who, even though he was the Lead, and he was very nice and everything but he – he used to always say that the medics had to declare their mental state stable, we never took referrals for people who were psychotic. He used to defer to psychiatrists and always thought that diagnostic, diagnoses were useful and valid.

Jon: Right.

Therese: I got a telling off once for saying transference in supervision.

Jon: Right.

Therese: And he was saying there was no evidence, it's controversial, don't say that. I had to remove ego-state from a formulation once.

Jon: That's amazing, ehm, the pot calling the kettle black in terms of no evidence for transference but we'll go along with schizophrenia.

Therese: And then, em, he was criticising the idea of socially constructed ideas – I think it was the University of East London or something, I kind of nodded and he said, "I hope you don't agree with them!"…These kind of …. left, liberals in London!

Jon: Right.

Therese: And they had this idea that it's all socially constructed. It was because we had a new psychiatrist come in and (my supervisor was) saying that this was fantastic because now we have somebody who can lead the team.

Jon: Okay. So how did that influence you at that time? So, you had someone more deferential to diagnosis, were you at the time – and it was only after that that you heard Richard Bentall and you were, em, heard some critiques of the twin studies, ehm, so were you much more, at that time, ehm, adopting a similar position to this supervisor?

Therese: The validity of schizophrenia. So I think I – I mean I go on to say towards the end, I probably would have disagreed because it just doesn't sit with me, it just wouldn't have

sat with me, it didn't make any sense. I think I said that we always try to categorise and group things.

Jon: Ye.

Therese: And that's part of what humans do.

Jon: Ye. Em. Where does that idea come from do you think?

Therese: Where does that idea come from?

Jon: Ye.

Therese: Eh – I just think that's something that we do.

Therese: I think it comes from emm…. social psychology teaching. So, that's probably where I thought that's where that view comes from.

Jon: Okay, right. Mm. Right. ….

Therese: So I think that's one of the things I think drives the classification, the diagnosis and it's probably just a flaw in our, in the way we think.

Jon: Ye.

Therese: And the way we, ehm, approach other behaviours and groups and people.

Jon: Mm.

Jon: And were reading other things? What other influences can you think about?

Therese: Ye, so I think, in the end, well, the last page, em, I go on to say about how, I volunteered for a few years in Dublin for SHINE Ireland. It's an organisation for people and families affected by psychosis. The director has experience of psychosis and loads of people who worked there, you wouldn't really know, it's was not really relevant.

I went on to say, eh, Ivor Browne is somebody I would have just come across through seeing him on television.

Jon: Right

Therese: He's a psychiatrist for the writer Colm Toibin so he'll often mention him in interviews and stuff.

Jon: Okay, right.

Therese: So, ehm, in Ireland, Ivor Browne kind of crops up occasionally.

Jon: Ye.

Therese: So, he would be on quite a lot and he's always very critical of psychiatry. He's very well known in Ireland but he's critical of psychiatry, very much so. He's often in the

public eye, so I would have come across him, again, not through em, like, a working role or anything, just from following what he says, em -

Jon: Mm.

Therese: And I quote one of the views that he holds and that would resonate with me, that's probably something that I would think as well.

Jon: Right.

Therese: Em, so it's all about how, doctors will assume that it's a disturbance in your biochemistry, that's related to some sort of genetic thing, but what he says about how, em….our behaviour has an immediate and far-reaching affect in our chemical imbalance, kind of which comes first, the chicken or the egg.

Jon: Ye.

Therese: And it's very dynamic.

Jon: Mm.

Therese: And about how what happens in a person's past and their present, can, that can be what can disturb the biochemistry rather than that it's the other way around.

Jon: Ye, ye.

Therese: Em…and then I go on to talk about, one of my favourite books. In the end, I think I got more ideas about the greyness from literature and the arts, and hearing critical ideas outside the context of work roles that more effectively capture the impact of social chaos and interpersonal chaos.

Jon: Mm-mm.

Therese: On maybe sensitive minds.

Jon: Mm.

Therese: And of course, in some instances those sensitive minds can sublimate into very creative eh, artistic things. So, one of my favourite books is Human Traces by Sebastian Faulks.

Jon: Right.

Therese: So, in that, there's the two friends -

Jon: Mm.

Therese: So, one of the characters, his brother starts off in the book kind of locked up in the stables and he's "mad"

Jon: Right.

Therese: But they both go on to become medical doctors, the friends, and they meet Charcot and all this, so it's very much – Faulks did loads and loads of research -

Jon: Mm.

Therese: For the book. In the end, they both go down different roads and fall out.

Jon: Right.

Therese: So, the one whose brother isn't mad, Thomas, he's convinced that schizophrenia is genetic -

Jon: Oh, okay.

Therese: And it's the price we must pay for the human mind.

Jon: Right.

Therese: And em, it's about, it's the price we pay as humans for having language.

Jon: Ye, ye, ye.

Therese: And then, whereas Jacques, he believes that em, schizophrenia is about em, suppressed childhood trauma.

Jon: Mm.

Therese: So, the whole book is about them.

Jon: Mm-mm.

Therese: Fighting it out. I need to re-read it really.

Jon: Mm-mmm.

Therese: But that was something that, em, cause he's one of my favourite writers, em,

Jon: Ye.

Therese: And just, reading, newspapers, literature, going to the cinema, that's probably where I would have, that's probably where the greyness probably comes from.

Jon: Ye.

Therese: Or that understanding.

Jon: Ye, ye,

Therese: Of humanity.

Jon: Ye.

Therese: Rather than anything – because I don't have the clinical experience.

Jon: Ye, ye.

Therese: So, I wouldn't be able to say – if I had more clinical experience, I might be saying something completely different.

APPENDIX G

EXTRACTS FROM REFLECTIVE DIARY

Extract 1

I am recording my thoughts, impressions and judgements after each interview. Going into the different stages of analysis I am conscious of some biases and how this might lead to criticism towards some participants at times. I need to keep in mind that my biases may favour some views over others, those more aligned with my own. In writing down my reactions to participants after interviews, I can hopefully identify personal feelings that have arisen for me so that when I start analysing, I know where I need to take more care.

Extract 2

I gained a valuable perspective today in volunteering to do an interview (April 2016) for another study relating to trainee's and qualified's experience of working with trauma. It was interesting to be on the "other side" and gain an appreciation of how it is important to feel listened to, feel that the interviewer is trying to establish a rapport. She seemed to stick rigidly to her interview guide and her posture was very stiff which made her seem cold and less genuinely interested.

Extract 3

I found her quite warm yet very intense (Prisha). The interview was longer than expected, but I still thought I missed opportunities to explore further how her views have been shaped by what she described as a privileged middle-class background. I was surprised to hear that psychiatrists would think that "schizophrenia" would be the most desirable group to work with because of predictability….

Extract 4

I found that it was a bit forced and I was "pulling teeth" a lot of the time. The interview did not flow particularly well and is probably going to be obvious after I get around to transcribing it. There seems to be something coming out about the emphasis on biology and dopamine during teaching. I wonder if this will be a feature of the rest of the interviews. I'm eager now to try to recruit another trainee to see if they have similar things to say – if it's a bit more "cut and dry" until you gain more experience in the job.

Extract 5

I was a bit concerned about how this interview would go, given that I knew in advance from email correspondence that he did not have a huge amount of experience working with psychosis. He did still meet the inclusion criteria in that he had some experience of working with psychosis. I was curious about the perspective of someone who had moved into an area where he would not be working with psychosis. Despite not working directly anymore, he was able to swiftly identify areas of contention, which were very interesting – the gulf between what we know and what we do not; the arguments for thought-patterns in ….the process of loss of creativity and original thinking in medical students over time; contesting the idea of psychosis as an "illness" in the first instance; the imposition of a formulation; personal meaning around psychosis; cases that confounded the evidence-base; the impact of psychosis on relationships with professionals; scrutiny of psychiatrists and their work. There was so much there!

Extract 6

I need to consider the vulnerability of participants, even if I do not agree with their views. Before the interviews started I was aware of my own struggles with psychiatrists who are closed off to psychological ideas or consideration of people's wider experiential, relational and social contexts. Nonetheless, I can still endeavor

to value and respect what they have said. If I cannot be neutral, which I don't think I can be, then at least I can be respectful and curious. I have noticed I am spending more time with the interviews from the biological psychiatrists now – I think I am conscious of possibly needing more time to deal with my own reactions to what they might be saying. I cannot but acknowledge my surprise that someone would think that a reductive dopaminergic view of psychosis is the most up-to-date but I can try to unpack why this might be the case and treat their interview with care, refraining from becoming critical and dismissive. These are exactly the kinds of perspectives I am interested in looking at after all. That was the whole idea.

APPENDIX H

GUIDELINES FOR TARGET JOURNAL

ETHICAL HUMAN PSYCHOLOGY AND PSYCHIATRY

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