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**A 'trigger', a cause or obscured?:
How trauma and adversity are constructed in psychiatric 'stress-vulnerability'
accounts of psychosis**

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Abstract

How do mental health professionals link adverse life experiences with the kinds of beliefs and experiences which attract a diagnosis of psychosis and what implications does this have for women with these diagnoses? Drawing on a broadly critical realist framework, we present data from two studies relevant to these questions. First, we analyse the discursive practices engaged in during a staff-only discussion of a female in-patient with a psychosis diagnosis who had been raped some years previously. Staff oriented to the irrationality and factuality of her ostensibly delusional statements about rape and pregnancy in the present and formulated adverse experience as a 'stress factor' triggering a manic episode, thereby precluding alternative contextualising interpretations. In a second, interview-based, study, psychiatrists drew on a range of discursive resources which differentiated psychosis from other forms of distress, constructed trauma as a stressor which could trigger psychosis because of a genetic predisposition, and constructed medication as the primary intervention whilst a focus on trauma was de-emphasised. We discuss the implications of these findings for the kinds of explanations and forms of help offered and suggest ways in which distress might be contextualised as well as possible future directions for feminist research and practice.

Keywords: Psychosis; trauma; stress-vulnerability; discourse analysis

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Feminists researching psychiatric diagnosis have long sought to make sense of women's psychological suffering by placing it in a political context, viewing it as a response to, often adverse, life circumstances but subject to medicalising discourse which obscures its social context (LaFrance, 2009; Warner, 2009). Just over a third of those with psychosis' diagnoses are women (Royal College of Psychiatrists, 2018) and they are particularly likely to experience both certain adversities and the medicalisation of their distress. Compared with men, women with psychosis diagnoses report higher rates of sexual and physical victimisation in childhood and adulthood (Read, Agar, Argyle & Aderhold, 2003); causal links have been identified between psychiatric constructs like hallucinations and delusions and childhood abuse and neglect (Read et al., 2003), as well as a range of adversities in adulthood, including sexual victimisation (Elklit & Shevlin, 2011). Yet DSM-5 links gender-specific constructs like 'post-partum psychosis' (also referred to as 'puerperal psychosis') with women's 'reproductive life cycle' and 'oestrogen variations' (American Psychiatric Association, 2013, p.15). Such reductive biological accounts locate the causes of distress in the female body and ignore the social context of distress and the varied meaning which childbirth might have for women (Nicolson, 2006). For those women who have been sexually abused, for example, aspects of childbirth and perinatal care can be experienced as a 're-enactment' of past abuse (Montgomery, Pope & Rogers, 2015).

In this article, we examine how adversity is constructed in psychiatric discourse about psychosis in a staff discussion of the ostensibly delusional beliefs of a female in-patient and in interviews with psychiatrists about the aetiological role of trauma. Our analysis is informed by critical scholarship firstly, on aetiology and treatment and, secondly, on the content of the unusual beliefs and experiences seen as 'symptoms' of psychosis. We briefly review work on these topics before discussing our research questions and methodological approach.

Assimilating adversity and prioritising medication

It is possible to theorise the impact of adversity on biological systems and the development of the kind of beliefs and experiences which attract psychosis diagnoses without recourse to biologically reductive theories of schizophrenia (Read, Fosse, Moskowitz & Perry, 2014). However, Mary Boyle (2013) has argued that it is much more common for psychiatric researchers to assimilate findings on adversity into their models in a manner that avoids or counters such interpretations. For example, childhood adversity can simply be included as one of a number of 'risk factors' within a discourse of epidemiological medicine. In a section headed 'neurobiologic and genetic factors', a recent overview of schizophrenia in the *New England Journal of Medicine* devotes one sentence to 'environmental factors':

...obstetrical complications, early-life adversity, and childhood residence in urban areas, putatively interact with genetic risks to influence liability to schizophrenia.

(Marder and Cannon, 2019, p.1753)

That these factors are stated to 'putatively interact with genetic risks' signals the influence of a somatogenic assumptive framework, despite the fact that this interaction remains unproven (Cromby, Chung, Papadopoulos & Talbot, 2019). Such views are not unusual: a study of articles published in the *American Journal of Psychiatry* between 2005-2007 found that 95.4% attributed psychosis predominantly to biological factors whereas the proportion was 75% for both the *British Journal of Psychiatry* and the *Canadian Journal of Psychiatry* (Jarvis, Bhat, Jurcik, Spigonardo & Whitley, 2015).

Zubin and Spring's (1977) 'stress-vulnerability' account of psychosis is a variant of the biopsychosocial approach currently popular in mainstream practice. It hypothesises that psychosis arises as a result of the way in which people differentially respond to life stresses as a result of 'inborn' or 'acquired' vulnerabilities. It frames potential adversities as stressors. However, Johnstone and Boyle (2018, p.6) argued that these models 'position social and relational factors as secondary to underlying biological causal malfunctions, and thus do not fully theorise distress as a meaningful, functional and understandable response to life circumstances'. The models achieve this effect, according to Boyle (2013, p.16) 'by "reducing" these life experiences either to *consequences* rather than causes or to *triggers* of biological predisposition, which act as the primary cause' (Boyle, 2013, p.16, emphasis in original). The trigger metaphor is common in psychiatric research including studies of 'puerperal psychosis' (e.g. Jones & Craddock, 2001).

Somatogenic accounts warrant the primacy of drug treatment. Thus, Blake, Collins and Seeman (2015, p.10) state that '[a]ntipsychotic medications are considered to be the foundation of treatment for psychosis' and, indeed, 97.6% of British people with psychosis diagnoses are prescribed such medication (Royal College of Psychiatrists, 2018). Within mainstream psychiatry, non-medical interventions play only an adjunct role. Marder and Cannon (2019) devote much of their review to medication, whilst Cognitive Behavior Therapy (CBT) is mentioned in a section headed 'management of a poor or partial response' to medication. Other psychosocial interventions are only briefly mentioned in relation to 'improving functioning' and they are said to be most effective only for those 'whose condition has first been stabilized with an antipsychotic medication' (2019, p.1758).

As Moncrieff (2013) shows, this focus on medication is justified by somatogenic theories like the dopamine hypothesis of schizophrenia although these are heavily contested. Moreover, she notes that these drugs have significant adverse effects on physical health, are of variable efficacy, and may be given compulsorily under mental health laws. Kilty's (2012) Canadian study demonstrates that women with psychosis diagnoses are not only overwhelmingly prescribed medication, they are also given little access to non-medical forms of help (Kilty, 2012). This means that women with

psychosis diagnoses may be denied opportunities to develop alternative conceptualisations of their distress, and this brings us to a second key issue – the way in which medicalisation obscures the meaningfulness of beliefs and experiences.

The meaning in madness and the decontextualizing effects of medicalising language

Johnstone and Boyle (2018, p.28) argue that medicalisation locates problems primarily in people's brains and bodies; this can 'obscure the well-evidenced causal role of social and interpersonal factors in distress and make it much more difficult to understand people's problems in the context of their lives and relationships'. Dana Becker's work on stress and trauma is a good example of this. Becker (2013) argues that these constructs focus attention on psychological and physiological factors within the individual and how they react to stressors and deflect attention from changing the social conditions which cause stress. The constructs of 'stress' and 'trauma' achieve these effects in a number of ways. For example, the external cause and its psychological consequence are often fused: 'trauma' is used to refer both to the traumatising event and its emotional effect. Moreover, both terms are reductive and euphemistic, and Becker questions whether complex and overwhelming feelings can be adequately conveyed by this vocabulary.

Clinicians are dissuaded from exploring meaning since 'it is not considered helpful or productive to deal with the content of patients' symptoms' (McCabe et al., 2002, p.1150). However, there is now an extensive body of work linking the content and phenomenology of voice-hearing to the social conditions of women's lives. McCarthy-Jones et al (2015, p.13) conclude that there is a relationship between 'women voice-hearers and trauma, abuse, oppression, and marginalization'. Researchers have given less attention to the meaning of ostensibly delusional beliefs which, in mainstream psychiatry, are regarded as inherently un-understandable. However, Barrett (1996, p.64) has noted that there is often a "kernel' of truth contained within a delusion' where elements of supposedly delusional claims turn out to be warranted whilst, in a study of psychiatric case notes, Read et al. (2003) found a striking similarity between the thematic content of supposedly delusional statements and documented abuse. These researchers suggested a number of possible explanations for this link, for example, that delusions might be attempts to make sense of 'abuse flashbacks by explaining them, in distorted fashion, in relation to the present rather than the past' (p.16)

Much of the critical work on which we have drawn has interrogated the published psychiatric literature, but talk is occasioned and shaped by its social context and is often less uniform than written texts (Georgaca, 2013). In this article, therefore, we examine micro-level discourse, presenting data from two unpublished studies conducted by trainee clinical psychologists. In the first study we analyse a staff discussion, during a multi-disciplinary team (MDT) ward round, of a female in-patient who had been raped some years previously and who was reported to hold delusional beliefs in which the thematic content concerned sexual violence and pregnancy. We identify the discursive practices engaged in by staff (i.e. the ways in which talk was organised to achieve interpersonal, institutional and other goals). But the meaning of distress may be obscured by the way in which mental health professionals talk about

it. In her conversation analytic study of in-patient treatment planning meetings, Goicoechea (2013) described how diagnostic discourse enabled staff to 'avoid the task of formulating connections between the individual and the social' (p.116). In one of the few studies to analyse how psychiatrists responded to ostensibly delusional beliefs in assessment interviews, the least frequent responses included tracing the history of the beliefs and exploring links with previous stressful experiences -- the kind of discussions which might have placed these beliefs in a social context (Zangrilli et al., 2014). However, Goicoechea's (2013) study did not include any extracts about apparently delusional beliefs whilst Zangrilli et al (2014) studied psychiatric assessment interviews rather than multi-disciplinary discussions. The research question we address in our first study is: How do staff in a MDT ward round discuss a woman's ostensibly delusional beliefs in the context of past adversity?

Our brief review suggests that a range of discursive resources is potentially available to mental health professionals when discussing trauma and psychosis. Discursive resources are the culturally available discourses people draw upon when giving accounts which construct particular kinds of objects (i.e. phenomena) and forms of subjectivity (i.e. ways-of being in the world). However, Isobel et al (2020) reported that, whilst their psychiatrist interviewees saw psychological trauma as relevant to some adult mental health problems, they viewed it as highly controversial in relation to psychosis. Only a short section of that article specifically examined psychosis so, we present extracts from another study relevant to our second research question, which is: what discursive resources do psychiatrists draw on in interviews about the role of trauma in the aetiology of psychosis?

We view these studies as complementary because interviews can help identify what discursive resources are available to professionals, whilst naturalistic talk can tell us how the everyday business of psychiatric work is actually conducted.

Methodological rationale

We draw on a different analytic tradition in each studyⁱⁱ but there is much debate in the field about whether such a dual focus may lead to theoretical and epistemological contradictions because of the different methodological heritages of Discursive Psychology (DP) and Foucauldian Discourse Analysis (FDA; Parker, 1997; Willig, 2013; Wetherell, 1998). Although there are cogent arguments for adopting an integrated analytic approach throughout (Lafrance, 2009; Wetherell, 1998), there are criticisms (e.g. Speer, 2007) and limitations of space preclude the detailed discussion of ontological and epistemological assumptions that this would necessitate. As a result, we present the two studies *seriatim* so that readers can bear in mind the differing theoretical assumptions brought to bear in each analysis.

Our underlying methodological strategy is informed by critical realismⁱⁱⁱ which involves three key elements (Pilgrim, 2020). Firstly, it is ontologically realist in that it assumes there is a potentially knowable independently-existing world in which causal influences are at work. We assume, for example, that human beings can harm each other and can experience distress though the historical and cultural

context will shape constructions of what is considered harmful and how distress is experienced.

Secondly, it is epistemologically relativist in that it assumes that the knowledge we gain of the world through our sensory capacities as social beings is partial and subject to revision and change (Chamberlain, 2015). From this perspective, and consistent with some pragmatist philosophical traditions (Chamberlain, 2015), all research methods are imperfect. Because of their different assumptions, every method simultaneously illuminates, but also obscures, some aspects of phenomena. Thus DP can inform us about how professionals actually talk about delusions in a particular case whilst FDA can inform us about the explanations available to professionals when they construct aetiological accounts of psychosis. At the same time, DP can place too much emphasis on the occasioned aspects of discourse identified via interactional turns, thus obscuring the context outside of the interaction. Similarly, FDA can reify discourse, endow it with too much agency and thus obscure how it is occasioned in particular interactions.

As Chamberlain (2015) notes, however, this epistemological relativism does not mean that our knowledge is arbitrary and this brings us to the third element of critical realism, the notion of judgemental rationality (Pilgrim, 2020). This assumes that we can evaluate different knowledge claims in a reasoned manner. This provides a basis not only for evaluating claims in a particular study but also for integrating findings from different methodological traditions.

Study I: How staff members discuss a woman's ostensibly delusional beliefs in the context of past adversity

This study (see Platts, 2006) focuses on discursive practice and draws on the tradition of Discursive Psychology which attends to: the action orientation of talk; the way in which talk is situated (sequentially, historically and rhetorically); and the way in which talk is both constructed and constructive (Wiggins, 2017). The extract is from one of the MDT staff-only ward round discussions, which occurred before or after service users and relatives joined the meeting. It was selected as it included a discussion of ostensibly delusional content and gender-specific aetiological factors. The study received ethical approval from both the University research ethics committee and an NHS ethics committee. Staff gave prior consent to the recording of the ward rounds and identified potential in-patients. Individuals were excluded from the study if it was considered that audio-recording might be harmful or where they were unable to provide valid consent. Consent was generally sought from in-patients and from carers before the ward round but, where this was not possible (e.g. if they had been on leave), provisional consent was obtained during the ward round and then revisited afterwards. The discussion was not recorded if anyone had withheld consent beforehand.

Participants

Recruitment took place on a mixed-gender psychiatric ward and the third author spent over five weeks on the ward introducing himself to all potential participants (i.e. service users and professionals) and presenting information about the study via individual and group meetings (e.g. at the ward Community Meeting). Five consecutive weekly ward rounds were recorded and transcribed involving the teams of two different psychiatrists. All participants are referred to by pseudonyms. In order to minimise the chances of identifying participants, their ages are reported in ranges.

The ward round discussed the case of Jennifer, a woman aged 30-39. Staff members present in the extract below include: Dr Arteta (a male Consultant Psychiatrist aged between 30-39), Dr Bashar (a female Senior House Officer aged between 20-29), Mariama (a female Staff Nurse aged between 30-39), Iris (a female Community Psychiatric Nurse [CPN] who was also Jennifer's Care Co-ordinator, aged between 50-59), and an undergraduate medical student (female, aged between 20-29). Also present at the meeting but who did not speak during the extract presented here were Ralph (a male Social Worker aged between 30-39) and Brian (a male nurse from the Home Treatment Team aged between 50-59).

Transcription

There was insufficient time to transcribe all ward rounds using full Jeffersonian transcription conventions as the study was conducted within the limited timeframe of a professional training and so a simpler form of transcription was utilised. For example, it was decided in advance not to focus on the contribution of pauses, intonation or emphasis during the analysis^{iv}. The following transcribing conventions were used:

| | |
|------------|---|
| (.) | A pause < 1 second |
| ((pause)) | A pause of 1-3 seconds |
| / | A speaker interrupts another speaker |
| (hormonal) | Inaudible material or doubts about its accuracy |
| [] | People speaking at same time |
| [laughter] | Additional or clarifying information |

Analysis

Jennifer had first come into contact with mental health services ten years previously as a result of a psychotic episode following the birth of her first child. During this ten-year period she disclosed that, some time before she became pregnant, she had been raped (there was no apparent connection between the rape and the

pregnancy). At the time of the ward round she had a diagnosis of Bipolar Disorder, had been on the ward for over six weeks and was being treated compulsorily under a Section of the Mental Health Act. She was discussed at four separate ward rounds and was prescribed psychiatric medication, but not reported to be receiving any non-medical forms of support.

The extract presented here occurred immediately after Jennifer had been interviewed during the ward round. In previous ward rounds, nurses had reported that, whilst an in-patient, Jennifer would visit a workplace where she had previously done voluntary work where, according to nursing staff, she would talk 'non-stop' about 'a lot of nonsense' resulting in her workmates contacting Iris (the CPN). The MDT had interpreted this as behaviour indicative of psychosis and that Jennifer was 'still high' (i.e. experiencing a manic episode).

- 305 Student: when did she start having (.) the manic (episodes), does it start
306 from when you're young or
307 (.)
- 308 Dr Bashar: she, she was admitted as a (.)
309 Iris: at first, the onset for her, it was after um, she had her first child
310 ((pause)) and there was another incident when (.) she was
311 raped ((pause)) that is true what she's saying, but the thing is
312 now, is that she keeps on about, that the rape is happening
313 now, the way she said it at work, when she turns up at this place
314 is like, "I've been raped, I, I'm expecting a baby"
315 [laughter – Mariama?] ((pause)) and she's been raped (.) gang
316 raped, and all sorts, I mean she can tell you the (name), the
317 tablets that they put in her drink. How do you know? "Well, I
318 came back and the drink was (.) you know, in a different place
319 where I put it" [Mariama laughs]
- 320 Dr Arteta: hmm
321 ((pause))
- 322 Iris: poor Jenny. Anyway, thank you very much, [will you] forward
323 me the (.) copy of the CPA, great thanks /
324 Dr Arteta: [thank you]
- 325 Student: I mean, was she completely fine before, before she had the
326 baby (.) before she was raped?
327 ((pause))
- 328 Dr Arteta: someti-, some er, you have (.) for example in, post-natal
329 depression (or), post-natal psychotic episode or, post-natal (.)
330 manic, manic episode sometimes, (hormonal) changes, or one of
331 the main factors that, trigger this, episode. Of course, any stress
332 factor could trigger (.) this situation

The extract begins with a request from a medical student (lines 305-306) for information on aetiology both specifically in relation to Jennifer and more generally in relation to similar cases. As Barrett (1996) notes, education of junior staff is one of the institutional goals of MDT discussions. Although there are a number of

analytically interesting aspects in the extract, here we will focus on how aetiology and the content of Jennifer's belief claims are discussed.

The description of 'onset' as occurring 'after um, she had her first child' (line 309) is followed by a report of 'another incident when (.) she was raped' (lines 310-311) which is accompanied by a validation of factuality: 'that is true what she's saying' (line 311). This appears to orient to statements (i.e. belief claims of rape and pregnancy) Jennifer had made in the immediately prior interview. The factual validation of two potentially aetiologically significant events makes their chronology relevant – rape is linked with Post-Traumatic Stress Disorder^v -- but the description of the rape renders the chronology vague as it is not temporally located in relation to other events (it is 'another incident': line 310), which de-emphasises its aetiological significance.

After this, Iris says 'but the thing is now' (lines 311-312) which serves to warrant a move from a presentation of the chronology of events in Jennifer's past to a description of her statements and behaviour in the present (lines 312-319). This account could be interpreted as rhetorically organised to counter the relevance of aetiological discussions, by presenting Jennifer's present statements and behaviour as bizarre, delusional and thus of more pressing concern. Thus, at lines 312-313 Iris reports that Jennifer 'keeps on about, that the rape is happening now'. This description presents Jennifer's statements as consistent with conventional psychiatric accounts of delusions: 'keeps on about' orients to preoccupation whilst the lack of accompanying factual validation from either Iris or other participants orients to falsity. This is followed by a description of Jennifer visiting her previous workplace. At lines 313-314, Iris says 'the way she said it at work, when she turns up at this place is like, "I've been raped, I, I'm expecting a baby"'. The lack of context-setting information and use of discursive devices (Wiggins, 2017) like reported speech (i.e. where a speaker appears to provide a literal representation of something previously said) and extreme case formulation (i.e. where extreme examples are given to strengthen an argument) increase the vividness of this account and emphasise the incongruity of Jennifer's conduct and her preoccupation with ostensibly false beliefs. As Smith (1978, p.23) has noted, descriptions of "'mentally ill type" behaviour' present it as anomalous, not making sense to others and 'not properly provided for by relevant social rules or definitions of the situation'.

Similar discursive devices are used in descriptions of Jennifer's claims that she has been 'gang raped' (lines 315-316) and that tablets have been put in her drink (i.e. that her drink has been spiked; lines 316-317). In a question and answer exchange, presented as reported speech (lines 317-319), Jennifer's response is presented as unpersuasive and its bizarreness is emphasised by noting that 'she can tell you the (name), the tablets that they put in her drink'. That an account presented as delusional incorporates such specific detail increases its incongruity -- the laugh from Mariama, the staff nurse, suggests that this description can be interpreted as having been constructed as bizarre by other participants. Barrett (1996) reports that staff-only discussions of behaviour or speech judged to be bizarre were often accompanied by laughter and descriptions highlighting their apparent absurdity. He also observes that such an exchange may be followed by a participant making a more sober and sympathetic statement, as occurs at line 322 when Iris says 'poor Jenny'.

The medical student asks a further question at lines 325-326 including both the rape and birth as of potential aetiological relevance and asking whether Jennifer had been 'completely fine before'. In Dr Arteta's response, the term 'post-natal' is repeated three times (lines 328-329), referring to psychiatric diagnostic categories, but the rape is not mentioned. The possible reference to hormonal changes (line 330) appears to orient to somatogenic explanatory accounts of these diagnoses. Dr Arteta then states that 'any stress factor could trigger this episode' (lines 321-322). This formulation could be seen as rhetorically organised to counter accounts that emphasise how different adverse life events might have different effects, and the phrase 'any stress factor' has two important effects. Firstly, events preceding the episode are treated as equivalent. Secondly, they are made relevant only in relation to the stress they cause. The trigger metaphor could be seen as having a similar effect in that past events are relevant only to the extent to which they act as a trigger. Agency is thus placed elsewhere – in an ambiguous and latent entity or process, possibly the 'episode' -- and other potential formulations linking past events and Jennifer's current statements and behaviour are de-emphasised.

Two institutional goals appear to be relevant to the participants. Firstly, participants are oriented to an educational goal (responding to a student's questions). Secondly, participants are oriented to presenting a description which is consistent with Jennifer's psychiatric diagnosis: her behaviour is explicable as a symptom of a manic episode (rather than other candidate diagnoses) and past events in her life are linked to the episode only as triggers.

Alternative non-medical formulations of Jennifer's troubles or psychiatric formulations which might place more emphasis on the rape, are 'hearably not part of' (Wetherell, 1998, p.404) the discussion. Their absence has the effect of precluding the possibility of other forms of help or understanding. As noted earlier, medication (which was being given compulsorily) was the only intervention mentioned at the ward rounds where Jennifer was discussed though, of course, we do not know to what extent alternatives might have been discussed previously.

We draw next from an interview-based study since such studies enable access to a broader range of discursive resources.

Study II: Discursive resources drawn on by psychiatrists in talking about the role of trauma in the aetiology of psychosis

This study (see O'Donnell, 2014) focuses on discursive resources and draws on the Foucauldian Discourse Analytic tradition. Since the data are derived from interviews of psychiatrists by a psychologist, readers should bear in mind that this context might occasion certain kinds of justificatory responses. The study received ethical approval from the University research ethics committee.

Participants

Potential participants were recruited via informal professional networks. They were informed that the study focused on whether the views held by psychiatric professionals about trauma and the aetiology of psychosis influenced their views about diagnosis, treatment and other aspects of care. The second author interviewed psychiatrists who responded. Once again, demographic details will be presented at the group level and ages are reported in ranges. Seven psychiatrists from NHS mental health services in London were interviewed. There were five women and two men, aged between 25-34 and 55-64 years old. Two participants were at a junior level, three were Consultant Psychiatrists and one was a recently retired Consultant.

Transcription

Given the focus on discursive resources, extracts are transcribed orthographically with punctuation, and line numbers are given for the extracts as a whole rather than on each line. Interviewees are referred to by initials. Brief interruptions by the interviewer are indicated by /. Pauses are not noted. Since the questions and responses were quite long and we wished to include a range of extracts, extracts are edited with omitted text indicated by ellipsis in square brackets: [...]. The interviewer's question is not included but is summarized before each extract so readers can understand some of the interactional context. Explanatory information is also presented within square brackets.

Analysis

Trauma as stress

When asked to define 'trauma', interviewees often drew on a discourse of stress:

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

The objects constructed here include trauma, stress and categories of abuse. The term 'trauma' appears to refer both to a traumatising event ('trauma could be anything like sexual abuse ...') and its effects ('trauma usually suggests something, severe stress') as observed by Becker (2013). Kinds of traumatising events are categorised by the mode of the abuse. Stress is constructed here as something which can vary along a quantitative dimension. As in the extract in Study 1, since the subjective impacts of traumatising events are only represented in terms of the amount of stress they cause, the complex range of feelings or meanings which might be associated with such events are thus obscured (Becker, 2013). Moreover, the terminology used precludes descriptions of the contexts and perpetrators of abuse.

De-emphasising adversity

When asked about the aetiology of psychosis, interviewees commonly referred to those attracting psychosis diagnoses as being predisposed in some way, though there was some variation in the extent to which agency was located in exclusively biological processes. Dr B had described different types of psychosis presentation and was asked whether they drew on different aetiological models if trauma was involved.

Dr B: [...] so basically if I'm genetically programmed to develop schizophrenia in the case of exposure to certain degree of distress, then I will become schizophrenic (258 - 261)

Dr B: [...] if I do not carry genes which predispose me to dopamine dysfunction in my brain, severe dopamine dysfunction, severe dopamine excess in my mesolimbic system then, I will be, even when exposed to severe stress during my childhood, I will probably be less likely to develop schizophrenia but I will be more likely to develop er er trauma related emotional er er instability, which will manifest in all sorts of behavioural outcomes of er behavioural symptoms of, of er borderline PD [personality disorder] (263 - 270)

Dr B presents a biogenic account which constructs a variety of key objects. A person can 'carry genes', which can 'predispose' to dysfunction and excess of the neurotransmitter dopamine (repeated three times). One can then 'develop schizophrenia' if 'exposed to severe stress'. This is contrasted with 'borderline PD' which is not associated with either genes or neurotransmitters. Here, 'severe stress' is associated with 'trauma related emotional ... instability' and 'behavioural outcomes' and 'behavioural symptoms'. This account appears to be rhetorically organised to counter an argument that the development of schizophrenia might be linked to the severity of stress – schizophrenia is less likely 'even when exposed to severe stress' if one does not carry genes predisposing to dopamine dysfunction.

Although the link between genes and the development of schizophrenia is initially framed deterministically ('I will be'), this is then qualified using more probabilistic terms ('I will probably be less likely'). This variation enables the account to counter a potential challenge to a more straightforwardly deterministic account; the dopamine hypothesis is heavily contested (Moncrieff, 2013) whilst epigenetic theories note how gene expression can be influenced by the environment (Cromby et al., 2019).

The hypothetical 'schizophrenic' patient is said to be 'genetically programmed'. This metaphor locates agency in genes and neurotransmitters rather than the person. The context and personal meaning of adverse experiences are absent – as in the extract from Dr G, subjective experience is represented within a vocabulary of stress which is constructed as varying only in quantitative terms, thus precluding other, more complex dimensions of subjective response.

Trauma as a trigger but not a cause

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

The construction ('a trauma') appears to fuse a traumatising event with its effects in a similar manner to the extract from Dr G's interview. Here the nature of environmental influence is described via a contrast between a 'cause' and a 'trigger'. This formulation appears to be rhetorically organised to counter an argument that a traumatic event could cause 'psychotic illness' without any intervening process. The trigger metaphor implies that a traumatic event only leads to psychosis because it has released a (not clearly specified) automatic mechanism. These metaphors preclude more complex descriptions of agency, subjective experience and context.

Trauma and treatment

In discussions of aetiology, interviewees drew on formulations which contrasted psychosis diagnoses with non-psychosis diagnoses as seen in the extract from Dr B's interview. Interviewees drew on a similar contrast formulation in talk about treatment. For example, following a discussion about schizophrenia and PTSD, Dr F was asked whether trauma played a different aetiological role in each.

Dr F: No, I think the role trauma plays is probably similar, but the illness is what's different /Interviewer: right/ so the diagnosis, treatment and outcome of schizophrenia would be quite different obviously to depression or P-, PTSD, so the different pathways, totally different emphasis on medication perhaps someone with depression after PTSD may not need medication at all
/Interviewer: mmm mmm/ they'd just need maybe the right kind of psychological therapy. Whereas with schizophrenia you're probably going to want to give them medication as a core part of the treatment /Interviewer: mmm mmm/ you know, not the only thing, but certainly it would be
/Interviewer: yeah/ a large part of it. (874-883).

A key object constructed here is 'the illness' and it is the difference constructed between schizophrenia and 'depression or P-, PTSD' which warrants the 'totally different emphasis on medication' in the treatment of each. Whilst depression or PTSD 'may not need medication at all' and maybe only require 'the right kind of psychological therapy', for schizophrenia, medication is 'a large part of' and 'a core part of the treatment'. Although other interventions are not excluded (medication may not be 'the only thing') they are constructed as secondary to medication. The warrant for medication, then, is 'the illness' and the role of trauma and aetiology are thus de-emphasised and seen as less relevant to the justification of medication as a treatment.

This de-emphasising of the role of trauma in treatment was seen elsewhere in the interviews. For example, Dr E was asked whether, if a person with a psychosis diagnosis disclosed having experienced trauma in the past, this would lead to a change in their diagnosis or treatment.

Dr E: I think, I think there isn't the time in the system that we work in. Not so much in our team, but in gen-, mainstream psychiatry /Interviewer: uhuh/ there is, isn't the time, the resources *et cetera* to, which is very sad for me to say, to, to explore that and to undo the problems and /Interviewer: yeah/ so therefore it's a repeating pattern that just gets reinforced and reinforced and then people /Interviewer: uhuh/ are in the system for twenty years and then you can't do anything about it /Interviewer: mmm/, they are just institutionalized. (409-417).

There are a number of interesting discursive features here but we will focus on discursive resources related to trauma and time. Firstly, time and resources are constructed as insufficient and this sets up a positioning of resource allocation and prioritisation though this remains implicit and accountability for such allocations and agency are seen as lying elsewhere. The lack of focus on trauma in treatment is seen as part of the taken-for-granted nature of 'the system'. The statement 'which is very sad for me to say' constructs the lack of focus on trauma as regrettable. However, Dr E does not say that, as a result, effective treatment is not possible. Thus a focus on trauma could be said to be constructed as a desirable but not necessary requirement of treatment. The object of trauma is constructed as something that could be explored and undone at an earlier stage but also as something that becomes less amenable to treatment over time. Agency is not located in the hypothetical patient here but, rather, in repeating patterns, reinforcement and institutionalisation and the outcome (i.e. when 'you can't do anything about it') is, again, constructed as inevitable. This formulation shares features with narratives of chronicity (Harper, 1999). As a result, a focus on trauma in treatment is constructed as desirable but not necessary whilst a failure to focus on it is constructed as the regrettable but inevitable result of factors outside of the individual psychiatrist's control. These two explanatory accounts provide a justification for why trauma might not be a focus of treatment both at an earlier time (because of lack of time and resources) and at a later time (because of institutionalisation).

Discussion

Although a number of our findings confirm previous work, the contribution of the present article is to show how, in Boyle's (2002, p.207) words, psychiatric discourse manages to make particular versions of reality 'seem reasonable'. Through a range of discursive practices and resources, somatogenic theories and treatments were subtly privileged with their contested status left unacknowledged, whilst other potential conceptualisations were de-emphasised. Here we make connections between some of the key discursive features and processes we have identified and previous work and discuss their implications for future feminist research and practice.

Constructing the aetiology of psychosis as inherently different from that of other forms of distress de-emphasised the role of adversity: causal agency was located in a latent genetic predisposition, represented through the use of the trigger metaphor. As in Isobel et al's (2020) study, our psychiatrist interviewees differentiated between the role of trauma in the aetiology of other problems and its role in psychosis. However, in contrast with their study, our interviewees did not regard the aetiological role of trauma as 'contentious' or 'risky'. Rather, adversity was framed as triggering

an unidentified but agentic entity or process. This suggests that a crucial function of stress-vulnerability and genetic predisposition accounts of psychosis is to 'ensure that social and psychological factors do not appear to be primary causes of mental distress and therefore primary targets for intervention' (Boyle, 2013, p.14). The persistence of these causal explanations, still unproven despite much well-funded bio-genetic research (Cromby et al., 2019), merits further research.

Biopsychosocial and multi-factorial accounts are highly flexible (Harper, 1999; Horton-Salway, 2002) and can thus enable 'the sheer adaptability of the medical model and its power to shift our attention, to invalidate, assimilate and neutralise challenges' (Boyle, 2013, p.20). As a result, it is important to remain vigilant about the way in which findings on the impact of adversity can be assimilated into biologically reductionist models through a focus on brain development (Wastell & White, 2017). Trauma discourse, as Becker (2013) has noted, affords only a restricted range of subject positions for service users and, as it becomes increasingly prominent, researchers could attend to how it is used and the ways in which it may be recruited into biomedical narratives.

Constructing psychosis as inherently different from other forms of distress enables the content of unusual beliefs and experiences to be viewed simply as a manifestation of an illness rather than being intelligible in the context of past adversity. The categorical difference constructed between psychosis and normal experience can be countered by showing how the apparently 'abnormal' responses of clinical populations lie on a continuum of responses within the general population, drawing on studies identifying the varied ways in which the non-clinical population respond to adversities (Boyle, 2013). Feminist work can render distress intelligible by drawing on a range of alternative conceptual frameworks to place it in its social context.

Although not explicitly feminist, an increasingly influential contextualising perspective is the 'trauma-informed' approach which assumes that many, though not all, psychiatric service users may have experienced adversities including traumatising experiences (Sweeney & Taggart, 2018). As psychiatric survivor Jacqui Dillon puts it, 'instead of asking people – what is wrong with you? We ask people – what has happened to you?' (Dillon, 2011, p.155). Within the Hearing Voices Movement, many members report that their unusual experiences and beliefs are intelligible in the context of abuse in childhood and adulthood (Corstens, Longden, McCarthy-Jones, Waddingham & Thomas, 2014) as demonstrated in a collection of fifty first-person accounts (Romme et al., 2009). A related approach is to reconceptualise psychiatric 'symptoms' as coping strategies which women have utilised to survive traumatic experiences (Warner, 2009). The *Power Threat Meaning Framework* (Johnstone & Boyle, 2018) suggests that people ask 'What did you have to do to survive?', proposing that human beings may respond to the threats posed by adversities in a range of ways, serving different functions.

In Study 1, falsity and bizarreness were emphasised as the most relevant aspects of Jennifer's beliefs and this enabled them to be seen as manifestations of a 'manic episode'. But the literal or 'historical truth' of statements is only one aspect of meaning – another is their 'narrative truth' (Spence, 1982). Focusing only on the literal truth of Jennifer's belief claims precludes the possibility that they may, when

understood using a more contextualised approach, be intelligible and meaningful in the context of her life history (Montgomery et al., 2015; Read et al., 2003).

In the studies, medicalising discourse constructed psychosis as inherently different from other forms of distress, obscured the role of adversities and the social context and decontextualized potentially meaningful beliefs and experiences as “symptoms.” An outcome of this is, as Warner (2009, p.17) has argued, that ‘[t]reatment is then orientated away from women’s lives (e.g. exploration of what they do to cope) and back towards internalized disorder (e.g. pharmaceutical management of their “disease”)’. Whilst, in our data, there was no frank dismissal of non-medical interventions focused on the legacy of adversity, they were ascribed a secondary role, as other researchers have found. Isobel et al (2020, p.3) note:

Mostly, awareness of trauma did not directly alter psychiatrists’ approach to treating mental illness. In acute settings, trauma treatment was considered secondary to stabilising symptoms and crisis resolution.

A systematic review of international studies (Read, Harper, Tucker & Kennedy, 2018) found that even when adults disclosed childhood adversity, it was often not included in formulations or treatment plans and medication was the primary intervention. Also, only a minority of people were referred for psychological therapies, something Kilty (2012) found in her sample of women with psychosis diagnoses in Canada. There is a need for more critical scholarship which engages with the way in which medication is prioritised in a range of publications (e.g. Blake et al., 2015; Marder & Cannon, 2019).

Despite academic debate about the aetiology, diagnosis and treatment of psychosis, there was little acknowledgement of this in our data apart from some evidence of hedging, and the use of qualifications and disclaimers. As a result, it would seem that service users with psychosis diagnoses are unlikely to be made aware of the contested status of psychiatric knowledge and practice, information which would likely influence their decision-making. For example, in Billcliff, McCabe and Brown’s (2001) study of long-term psychiatric in-patients, the majority of whom had a diagnosis of schizophrenia, 81% of their sample did not know any of the adverse effects of their medication and most thought they had no choice in whether to take them. Researchers could evaluate interventions designed to provide service users with such information.

The discursive resources drawn on by our participants in accounts of aetiology and treatment afforded those with psychosis diagnoses relatively little agency. The potentially varied meanings of -- and responses to -- adverse experiences were absent. The dominance of a biomedical frame of explanation and treatment precluded the possibility that those with psychosis diagnoses might wish to access a range of alternative explanatory frameworks and forms of help. However, British psychologists have begun to more assertively denote the medical approach to psychosis as only one of a number of different approaches, arguing that service users should be enabled to make informed choices from a range of alternatives – including not only psychological therapies but also community and peer-led approaches (Cooke, 2017). In her discussion of peer-led hearing voices groups, Gail Hornstein (2013) emphasises the importance they place on validating a range of

explanatory accounts and she also notes the way in which the groups engage in a collective exploration of the meaning of voices, practices which have a broader resonance with feminist practice.

Our approach is open to a number of criticisms. FDA researchers might criticise the analysis of Study 1 for an insufficient attention to influences outside the text whilst DP researchers might argue that we have not sufficiently attended to the occasioned aspects of talk in Study 2. Both groups might also argue that the analysis in each study is not internally consistent. Lastly, our approach could be criticised for a selective approach to epistemology or an unsystematic application of analytic methods across the two studies (Speer, 2007). Our hope is that the analyses of the two studies have been consistent enough to be persuasive and that readers will agree that the problems involved in drawing on two methods are outweighed by the potential benefit of gaining a fuller understanding of psychiatric discourse and its effects.

In conclusion, constructing the unusual beliefs and experiences of women with psychosis diagnoses as symptoms of an illness which requires medical treatment (i.e. medication), not only obscures the links between adversity and the suffering it causes, but it also limits the horizons of intervention. As Becker (2013) has argued, stress and trauma discourses not only provide a limited vocabulary for describing adverse events with complex emotional responses but they also direct attention away from trying to change the social conditions which cause them. Research on the impact of Adverse Childhood Events is increasingly influencing policymaking in education and health and social care (Wastell & White, 2017). Although a focus on adversity is welcome, the danger is that policy may only be directed toward ameliorating and treating its effects once it has occurred. We need, instead, to place much more emphasis on preventing such experiences from happening in the first place.

Dedication

This article is dedicated to the memory of Professor Marcia Worrell who sadly died while it was being written. Marcia had a longstanding research interest in how childhood adversity was discursively constructed, having focused her PhD on this topic. Feminist psychology has lost an important voice, but her influence will live on through the contributions she made to the field and in those whose lives she touched.

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Biographical note

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ⁱ The term 'psychosis' is increasingly used by mental health professionals to cover a broad range of diagnoses like schizophrenia, bipolar disorder and other schizophrenia spectrum disorders though it fails to resolve their longstanding conceptual problems (Boyle, 2002, 2013).

ⁱⁱ Readers are directed to O'Donnell (2014) and Platts (2006) for detailed information about the procedure and analytic steps in the two studies.

ⁱⁱⁱ This again is a topic of considerable debate and readers are referred to Chamberlain (2015) and Willig (2012) for an extended discussion of the compatibility between versions of social constructionism and critical realism.

^{iv} To avoid such *a priori* decisions Wiggins (2017) suggests transcribing only those extracts which are to be analysed.

^v 'Post-partum' onset is seen as a specifier for diagnoses of mania and depression in DSM-5 (American Psychiatric Association, 2013, p.15) but there is no similar diagnostic specifier for psychosis following sexual violence. DSM-5 mentions rape specifically only in the description of Post-Traumatic Stress Disorder.