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# To what extent do clinical psychologists working in early psychosis routinely explore trauma with their clients?

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**ABSTRACT**

Objectives: The study explored the extent to which a sample of clinical psychologists in Early Intervention Psychosis (EIP) services routinely investigated trauma with clients. An abbreviation was used for experiences related to 'severe adversity, abuse, or trauma' (AAT).

Method: A novel vignette-semi-structured telephone interview approach was used. To avoid limiting conceptualisations of these phenomena, for example by solely considering trauma as a contributory or aetiological factor in psychosis, the study was designed to allow wider exploration of relationships and other key factors.

Results: The majority of the sample reported routine investigation of AAT with clients, assuming broad definitions, and assessment procedures were collaborative and client-led. An appropriate context was deemed necessary before trauma was explored, including engagement and a psychologically safe environment. The overall findings highlighted explicit investigation of, broadly defined, trauma-related issues within heterogeneous approaches to working with psychosis.

Conclusions: While trauma was one key factor, links with psychosis were complex in practice. Participants appeared to operate within a more complex understanding of psychosis than researchers may sometimes be willing to promote.

## Introduction

There is limited understanding of clinicians' real-life practice, and specifically whether elucidating trauma-psychosis links may lead to a greater degree of trauma-focussed formulation and changes to therapy processes (Duhig *et al.*, 2015; Sweeney & Taggart, 2018).

There is emerging literature highlighting traumatic and adverse experiences as a significant risk factor for a number of mental health problems, including psychosis - a robust finding at all life-course stages and across cultures (Campodonico, Varese, & Berry, 2022; Kessler *et al.*, 2010). Precise definitions for the terms 'trauma' and 'abuse' are difficult to ascertain and this is likely to impact upon the interpretation of associations.

Well-documented conceptual issues exist with the term 'trauma', both in terms of defining the nature of triggering events and the reactions to these events; this paper is primarily concerned with the latter. It is generally acknowledged that the concept of trauma has broadened, and the resulting 'bracket creep' - whereby ordinary stressors might be deemed capable of triggering post-traumatic stress disorder (PTSD) - as outlined by McNally (2010), has important implications for theory and practice. Whether an event has to satisfy conditions for a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis to be considered 'traumatic' is subject to contentious debate (American Psychiatric Association, 2013). For the purposes of the current study, and similar to Varese *et al*. (2012), wider 'severe adversity' was included as well as 'abuse' or 'trauma', thus going beyond conceptualisations of PTSD. Corstens and Longden (2013) also adopt broader conceptualisations, including childhood adversity, neglect, familial conflict, bullying, physical, sexual, and emotional maltreatment, in examining links between broader life history and voice hearing experiences. In the current study, an abbreviation was used for events and

experiences explicitly related to 'severe adversity, abuse, or trauma' (AAT); this was deemed necessary in order to reflect the potential diversity of the experiences that clients and practitioners might consider to be significant, and also to avoid over-specifity in the focus, which risked potential omission of events identified as important by clients and practitioners.

### *Background Information*

Little is known about how clinical psychologists formulate and conceptualise links between trauma and psychosis in clinical practice. Not all individuals exposed to AAT develop psychosis, and not all individuals experiencing psychosis report AAT histories. However, considering the developing evidence base, the current article focuses specifically on AAT-psychosis links.

#### *Empirical evidence linking trauma and psychosis*

Significant associations have been identified between adversity and psychosis across all designs, with an overall effect of OR = 2.78 (95% CI = 2.34–3.31), suggesting childhood adversity has a strong association with increased risk for developing psychosis (Varese *et al.*, 2012). Further evidence comes from studies connecting traumatic experiences and content of unusual experiences. Indeed, mediation analyses are helping identify potential mechanisms as foci for more targeted interventions to better support people experiencing paranoia and voice hearing (Pearce *et al.*, 2017); however, trauma-psychosis links remain complex, and even systematic reviews reveal inconsistent findings (Read, van Os, Morrison & Ross, 2005).

## How Do Trauma-Psychosis Links Impact Upon Therapy Processes?

#### *Clinical intervention for psychosis: inquiring about trauma*

There is little clinical research on the use of therapies targeting post-traumatic stress symptoms in individuals with a history of trauma and psychosis diagnosis (Cragin *et al.,* 2017). To date, clinical interventions to treat trauma in individuals with psychosis have mainly focused on treatment of PTSD. However, a Cochrane review investigating the effectiveness of psychological interventions for PTSD symptoms, or other symptoms of psychological distress arising from trauma in people with severe mental illness, concluded that meaningful conclusions cannot be drawn due to the limited number of trials available (Sin, Spain, Furuta, Murrells & Norman, 2017). Many authors stress the importance of investigating traumatic experiences with clients experiencing psychosis (Kilcommons & Morrison, 2005; Morrison, Frame & Larkin, 2003; Read et al., 2005); this recommendation has been included within the United Kingdom's (UK) National Institute for Health and Care Excellence guidance (NICE, 2014). Morrison *et al.* (2003) attempted to integrate evidence suggesting that trauma can have an aetiological role in psychosis, that psychosis can itself lead to the development of PTSD, and consider whether both phenomena could be conceptualised as part of a spectrum response to adverse life events.

There remain important questions regarding how, and how commonly, clinicians assess trauma in practice (Cunningham, *et al.,* 2016). Evidence suggests that a large proportion of clients with abuse histories are never asked about their experiences by mental health staff, and it is uncommon that survivors spontaneously disclose of their experiences (Agar & Read, 2002; Read et al., 2007; Read, Harper, Tucker, & Kennedy, 2018; Neill & Read, 2022).

*Clinicians' experiences of inquiring about trauma and abuse*

The literature is not clear about the most appropriate time to explore trauma history. Although there is no consensus, the optimum time may be once rapport has been established, rather than inquiring at initial assessment (Bendall, Alvarez-Jimenez, Nelson & McGorry,

2013). However, it could also be argued that inquiring at initial assessment is more sensible clinically, one reason being that it minimises the risk that trauma is missed altogether. Either way, failure to assess for trauma may impede consideration of appropriate treatment strategies and could unnecessarily prolong individuals' distress (Morrison, Read & Turkington, 2005).

### *Study aims*

There is currently little research addressing the way clinicians make sense of trauma-psychosis links, and how this impacts on therapeutic decisions and processes in practice.

The research question read as follows: to what extent does a sample of clinical psychologists working in early psychosis routinely explore AAT with their clients? 'Extent' here relates to the issue of quantification. The frequencies of relevant category codes and themes revealed the proportion of the sample that mentioned particular meaning-units. The word 'routinely' was taken to mean clinicians' broad reflections on normal practice.

## Materials and methods

### *Participants and design*

Eleven participants (five male; six female) were interviewed about their conceptualisations of psychosis and clinical work. All participants were practising clinical psychologists working in Early Intervention Psychosis (EIP) services, and were recruited from across seven NHS trusts in England. Experience of working specifically in the field of psychosis ranged from

less than a year to 13 years (mean of five years) and interviews lasted between 41 and 54 minutes.

This qualitative study adopted a vignette approach in combination with a semi-structured telephone interview. This included: part A, a case reflection, grounded in a real case and what the participant reportedly did; part B, responses to a hypothetical case vignette and inquiring about how the participant might approach this fictitious, but plausible, case; and part C, more specific questions seeking reflections on AAT-specific issues, for example definitions and how links with psychosis were understood.

*Vignette construction*

A vignette character was generated by the research team. The vignette itself provided sufficient contextual information for respondents to understand the situation, but enough ambiguous information to ensure that multiple 'solutions' existed. The vignette was 450 words in length, focussing around a 28 year old hypothetical character (available upon request). The information outlined recent onset of voice hearing and paranoia in the context of stressful life events; it also hinted at potentially difficult experiences earlier in the character's life.

*Semi-structured interview*

The vignette-semi-structured interview approach allowed for application of two separate data analysis techniques. Content analysis was used to help gauge the frequency of certain factors within data. However, this approach was not necessary for all data, and the use of a three-part

procedure meant that distinctions could be made between data from parts 'A/B' and 'C' separately; this allowed a more simple thematic analysis of part C data, which was concerned specifically with AAT-specific responses. Interviews were conducted by the first author.

*Part A- Case Reflection*

Participants were asked to reflect on a real complex case, with their client engaged in therapy for at least three months. They were invited to talk for approximately five to 10 minutes about their perceptions of the salient factors contributing to this anonymised client's experiences of psychosis, and how their formulation had informed clinical work. This provided data, rooted in participants' perceptions of real-life practice.

*Part B- Vignette*

Participants were asked to imagine the vignette character had been referred for assessment and psychological therapy. They were invited to 'think aloud' their initial responses to the clinical vignette. Participants were asked to consider the potential factors which may contribute to the fictitious client's experiences of psychosis, information necessary to best make sense of their experiences, and ideas regarding possible options for therapy. This part of the procedure was designed to primarily explore the 'assessment phase'.

*Part C- AAT-Specific Questions*

The AAT-specific semi-structured interview questions related to information gathering processes, conceptualisations of AAT, AAT-psychosis links, and how AAT-information informed therapy processes. Participants reporting at least one criterion from a devised checklist, geared towards mention of AAT, were asked further AAT-specific questions. The criteria contained a range of common AAT-related client experiences; for example trauma

(e.g. specific incident or ongoing), adversity (e.g. poverty or severe chronic stressors), but also included adverse life experiences such as bullying.

### *Recruitment strategy*

#### *Sampling*

Qualified NHS clinical psychologists working in early psychosis (aged 14+ clients, first episode within preceding three years) were approached as potential participants. In the interest of maximising representativeness, the largest eight English cities with local EIP services were identified.

#### *Recruitment*

Participants were recruited from seven of 12 approved NHS trusts. Local collaborators were identified in all approved NHS trusts and potential participants were approached via email, inviting participation in a single interview. It was important that participants were not primed to the study's focus on AAT-psychosis links. Study information outlined that the researchers were investigating how clinicians formulated 'different factors' in understanding clients' experiences of psychosis, and how these informed therapy processes. Participants were sent a covering letter and case vignette a week in advance of the interview. Consent was obtained via electronic signature on a consent form, and again verbally after each debrief, as the participant information sheet omitted the study's AAT-psychosis focus (as in Carr, 1999). The AAT-focus was explained during the debrief.

*Procedure*

Participants engaged in a single telephone research interview lasting approximately 45 minutes. The semi-structured interview was comprised of a three-part procedure (parts A, B, and C). Telephone interviews were recorded and transcribed. The study received ethical approval, and recruitment and interviewing was completed over a five month period.

## *Data Analysis*

Content analysis was used to analyse data from parts A and B. This method allowed some degree of quantification with regards to the extent that AAT-related meaning units appeared within the data, as relevant to the research aims. Content analysis was not appropriate for part C data, as questions and responses were already AAT-specific in nature. Thematic analysis was therefore used to examine part C data.

*Content Analysis*

Content analysis has been used specifically with vignette methodology and data collected from telephone interviews in health research (Carr, 1999). This method is concerned with meaning as much as frequency counting, though the overall aim is to produce a condensed and broad description of phenomena (Cavanagh, 1997).

*Stages of content analysis*

The content analysis progressed according to three main stages: preparation, organising, and reporting (Elo & Kynga, 2008), leading to an initial coding framework. A coding framework

was produced using the stages outlined above. This was used to initially analyse parts A and B of the first two interview transcripts. The revised categories and coding framework were pre-tested to the point where ambiguity over the code assignment process was appropriately resolved, as suggested by Cavanagh (1997). As there was some degree of interpretation regarding what was included in the AAT-related categories, coding framework rules were devised to maximise consistency. Several drafts of the coding framework were created before analysis of remaining transcripts commenced.

Inter-rater reliability was established by engaging two independent trainee clinicians in a reliability checking exercise; agreement was classified as a code assigned from the same category as the lead researcher's assigned codes. Cohen's kappa (κ) was calculated to assess inter-rater agreement revealing κ values of 0.61 and 0.63 respectively between the lead researcher and the two independent raters; these values are within Landis and Koch's (1977) range for 'substantial agreement'.

*Process of analysis*

Following the complete coding of part A and B data, code frequencies were tabulated from all part A and B transcripts, and codes and code clusters identified relevant to the research question (50 codes across three broad categories relevant to assessment/exploration of trauma). Being able to comment explicitly on AAT-related patterns within the data was essential in addressing the research question.

*Thematic analysis*

Thematic analysis was used to analyse part C data, and allows researchers to identify, analyse and report patterns or themes within data (Braun & Clarke, 2006). A focus on the critical elements within part C data was required, rather than considering the entire data set. The six thematic analysis phases outlined by Braun and Clarke (2006) were followed. Themes were defined and described in a way which captured the most meaningful aspects within the data in relation to the research aims. Data were coded and themes were generated by the first author and wider research team.

## Results

The analysis is presented in separate sections as relevant to the research question. The most relevant and commonly occurring codes/themes are presented, as identified from the content analysis of A and B data, followed by part C thematic analysis.

*Part A and B data – case discussion and vignette*

Relevant categories and the codes they contained were drawn from the final coding framework, and code frequencies were tabulated. The next stage involved a systematic approach of highlighting codes which appeared in at least three participant transcripts; this meant that codes were present across at least 25% of the sample.

The proportion of participants who reported specific codes is given, to provide insight into prevalence and assumed importance throughout the data. For example '8/11 participants' means the specific code appeared in eight of the 11 transcripts. The overall code frequencies

across the data are provided in some instances for the same reason; for example ‘f=16’ signifies a total of 16 code utterances across all transcripts.

*Part C data - AAT-specific questions*

A more interpretative thematic analysis was conducted on part C data. This part of the analysis did not seek to separate AAT from non-AAT-related meaning units to the same extent as with data from parts A and B. Most responses clearly related to AAT, and were coded as such. The same approach to that adopted for parts A and B, was used for the identification and reporting of theme prevalence (e.g. themes in at least three transcripts, then 4/11 participants, for example).

## ***Analysis***

*Summary of Findings*

The relevant themes derived from part A and B data are outlined in table 1. Prominent themes from part C data are outlined in table 2.

*[Tables 1 & 2 near here]*

Most participants routinely considered AAT and its sequelae in their clinical approaches. Data from parts A, B, and C supported this, and provided information of the salient details sought and the processes surrounding the gathering of such information. Whilst AAT-related factors were often explicitly considered, assessment procedures appeared to be collaborative and participants typically allowed the information-seeking to be led by the client in the context of a psychologically safe environment.

A range of factors that were not explicitly AAT-related, as determined by the authors, were highlighted in the data and were also commonly explored in routine practice. For example; the context prior to onset of symptoms, general life experiences, cognitive/schematic and/or emotional factors, interpersonal factors, and sense-making of experiences. Participants were seemingly trying to ascertain how clients think and feel generally, whether or not this was related to AAT. The findings highlighted explicit exploration of broadly defined AAT-related issues within complex approaches to working with psychosis, and focussed on participants' perspectives on clients' needs.

### *Parts A and B*

#### *Assessment factors*

*Seeking AAT-related information*

Participants' responses from parts A/B and C, participants' responses suggested that explicit AAT-related information was often sought during assessment stages. As outlined in table 1, contextual information proximal to psychosis onset was sought; for example:

*"I'd try and work with her I suppose on working out whether there's any persecutory beliefs, what is reality, was she actually bullied at work?" (P4)*

More than half of the sample sought AAT-related information relating to life events (such as 'sexual abuse' or 'traumatic memories'), early developmental context or clients' generic histories, without specifying life stages. A limited number of codes related to processes surrounding the manner in which AAT-related information was sought. Three participants discussed the existing research as a reason for further assessment. Codes not explicitly linked

to AAT-related life events and experiences appeared frequently; they warranted inclusion as they provided insight into other factors participants also considered in making sense of peoples' experiences, for example information relating to clients' strengths and values.

*Seeking information, not explicitly AAT-related*

The findings suggested that a wide range of factors, beyond those explicitly related to AAT, were commonly considered during assessment. General life events played a central role in conceptualisations of clients' difficulties within EIP services. As outlined in table 1, participants commonly sought information about the context prior to onset of unusual experiences. A key limitation was the difficulty in ascertaining whether participants were referring to events which may have met AAT-criteria without vocalising this explicitly.

One of the most prevalent codes related to information sought explicitly was clients' sense-making or appraisal of their experiences (10/11 participants). Information relating to 'cognitive/schematic and/or emotional factors' was common throughout the data. These terms were broadly defined by the research team to conceptualise heterogeneous forms of mental representation, where these were explicit in participants' responses; the researchers used 'cognitive/schematic factors' to code utterances relating to specific aspects of experience - arranging incoming information, generating meaningful perceptual, cognitive, emotional, and behavioural experience. Information relating to emotion, or the role of affect, was included as these factors were common but difficult to differentiate from cognitive/schematic factors in participants' responses. Information concerning cognitive/schematic factors and/or emotional responses not explicitly related to AAT, was commonly sought (9/11 participants, f=23).

Other key factors identified in the data, as outlined in table 1, were especially relevant to assessment processes, including interpersonal factors and relationships (i.e. immediately involving other individuals), wider social issues including systemic/cultural factors, information related to coping styles, details about clients' strengths/values, as well as information on biological or medical factors (including drugs and sleep deprivation), and risk issues. A limited number of codes related to the procedures surrounding assessment.

*Further assessment factors*

The overall pattern of the data suggested that participants routinely considered AAT factors in assessment. The data also suggested there may be many reasons why participants may not engage in assessment of AAT; participants tended to be systemic in being responsive to their clients' needs.

There was little evidence that participants used systematic procedures, defined in terms of using formal protocols, for assessing AAT. The data suggested that participants had client-dependent approaches to gathering information, or that they were not consciously elaborating on these processes. Clinical judgement was important in guiding information seeking processes not explicitly AAT-related (5/11 participants). Four participants suggested that engagement and trust were necessary before asking more specific questions, and this was not necessarily in the context of AAT. The data were suggestive of sensitive information seeking processes, even when unrelated to AAT, clearly drawing upon clinical judgement and experience. Data from part C supported some of these findings, and provided detail in some other aspects.

***Part C***

***Definitions and conceptualisations***

The data allowed exploration into the issues of defining trauma and other phenomena included within the AAT construct. As summarised in table 2, trauma was broadly defined, distinctly negative, and sometimes resulted from a developmental break that impacted on cognitive/schematic and/or emotional development.

Participants commonly defined trauma in a broad manner (7/11 participants), and the overarching message was one of heterogeneity. Participants commented upon the difficulty in providing a 'catch all' definition, and queried whether this was possible due to the individual nature of personal experience. There was the sense that broad and over-inclusive definitions of psychological trauma may not be particularly useful clinically either. Examples include:

*"I think it's really broad… what is trauma for one person isn't necessarily a trauma, the same degree of trauma, for another" (P10)*

Despite the difficulties in conceptualising AAT, the data suggested there may be something common in the type of reaction, even if the nature of events differed. However, less common themes communicated some relevant points of interest. Four participants discussed the notion of a significant psychological response resulting from a break in the expected developmental trajectory of a person's life, often in the context of significant life events. Here, clinicians seemed to be perceiving the disruption to the expected development as the traumatic event for the client, rather than the precipitating event itself, as the cause of the trauma. Finally, three participants alluded to trauma being linked distinctly to negative experiences. For example:

*"I think it shatters their sense of this as a safe world" (P1)*

Participants gave rich responses in relation to AAT-related assessment processes, as explored further below.

***Assessment related themes***

Many of the emerging themes outlined in table 2 confirmed points highlighted from part A and B; AAT-related information was frequently sought and, although not the focus of the current paper, this could be of potential relevance to participants' wider conceptualisations of psychosis. However, there was variation in the manner in which this information was sought and subsequently acted upon. Information seeking seemed to be conducted in a sensitive manner and was dependent on client-specific factors.

Nine of the 11 participants suggested that assessment of AAT-related issues was warranted. Participants commented on the central importance of assessing adversity, generally assuming a broad definition of AAT. Similarly, most participants elaborated on the type of information sought in the AAT context (7/11 participants). Unsurprisingly, significant life events and the subsequent impact on development, were important themes.

Most participants discussed the manner in which AAT-related information was gathered; assuming a collaborative approach to inquiry, considering appropriateness, the client-dependent nature of this, and the role of wider team involvement. Alluding to context dependent factors, a number of participants discussed the notion of a necessary context for more in-depth AAT assessment (5/11 participants). It was sometimes deemed inappropriate if the client did not wish for exploratory work, or if the risk level was too high. The need for appropriate timing was raised by 5/11 participants; perhaps being wary about conducting thorough inquiry into AAT too early in the assessment process. For example:

*"Usually it's something that comes over time ... people aren't ready to talk about that at the beginning of therapy" (P10)*

In summary, the above data goes some way in addressing the research question, suggesting that participants routinely considered, and sought, AAT-related information in their practice. The study suggested this tended to be routine but that clinicians adjusted their approach to fit with the clients' needs and presentation. There were clearly important processes surrounding the manner in which this was performed; clinicians were sensitive to the circumstances and presentation of the client. Issues of client willingness, appropriate timing, and the role of clinical judgement in assessing clients' readiness were of key importance.

## Discussion

The current study highlighted a number of findings relevant to assessment processes within the field of trauma and psychosis.

### *Key finding 1: the sample routinely explored AAT with their clients.*

Participants adopted broad definitions of AAT, with recent and historical AAT-related information sought during assessment processes. Reference to AAT was common throughout part A and B data. Whilst there are limits in assuming that higher frequencies were indicative of importance, the findings suggested that consideration of AAT-related factors was commonplace in participants' routine practice. In this way, clinicians were indicating that their practice was largely consistent with UK NICE guidelines.

Issues of definition are important here, particularly as the data-driven 'AAT' categories were wide ranging, and more inclusive than the adversities often outlined in policy. More

specifically, participants' mental models of 'trauma' appeared to be broad in nature; varied experiences had the potential to traumatise clients, or at least impact upon individuals significantly. Importantly terms such as 'abuse' were not synonymous with 'sexual abuse', and the findings support existing concerns about narrowly defining 'trauma' in the literature. Using 'AAT' as a means of acknowledging wide ranging adversity was useful in avoiding parochial ways of defining the phenomena involved.

Similarly broad conceptualisations were adopted in the current study, and the fact that wider definitions of trauma were endorsed by participants in relation to their clinical practice is an important addition to the literature. There were also notions of 'trauma' being distinctly negative, in the current study, and relating to a 'developmental break'. This was similar to the concept of 'disconnection' at different levels of functioning, outlined by Straker, Watson and Robinson (2002), and can be clinically useful as a means of helping describe and understand responses with clients.

The above complexity in defining AAT reflect wider issues within the trauma-psychosis literature. In essence many events can lead to reactions that might be described as traumatic responses, and participants appeared to navigate these complexities with relative ease; essentially, it is only in seeing individuals' reactions, or assumed outcomes, that events are described as being traumatic. Indeed using 'AAT' as a means of acknowledging wide ranging adversity was useful in avoiding narrow ways of defining the phenomena involved, i.e. beyond ideas of single/type I and extended/type II traumas.

It is acknowledged that the current study required a degree of artificial categorisation in considering 'explicitly-AAT' and 'not-explicitly-AAT' phenomena, and there are limits to the meaningfulness of such distinctions. Despite methodological challenges in attempting to

categorise clinicians' practice, and ascertain the precise contribution of AAT-related factors, the overall findings are theoretically and clinically useful.

***Key Finding 2: participants routinely explored a broad range of factors, often outside of the explicit AAT context.***

A range of factors were routinely explored by participants, many of which were not explicitly AAT-related. Why might participants more readily assess and discuss information not explicitly related to AAT, even though when explicitly asked (according to part C data), they suggest AAT is of central importance? Data from table 1 suggests that only 50% of the sample sought AAT-related information; perhaps AAT is not of central importance, as participants had suggested? Indeed, AAT was only one important set of factors alongside others that were considered important during assessment. This finding is relevant to the notion of trauma-informed services, as it underscores the reality that clinicians recognise a wide range of different relevant factors in practice-based assessment; the sample's approach was perhaps 'trauma-informed' but not necessarily 'trauma-focussed', and this reflection is of interest to those involved with service development.

The findings inform multi-factorial explanations of psychosis. Participants most commonly sought information regarding clients' sense-making or appraisal of their experiences, in addition to relevant cognitive/schematic factors and emotional responses. Other information commonly sought related to interpersonal factors and clients' coping styles. There is a growing literature base supporting the involvement of such factors, and it is not surprising that participants drew upon diverse information relating to relevant variables. This raises

important questions, however, surrounding the times when trauma-related responses might be neglected where clinicians adopt such a wide focus.

The current study's participants clearly considered it clinically important to address wider social factors – a more systemic orientation. A benefit of the current study's procedure was that it allowed participants to reflect on whatever factors were perceived as salient (parts A and B). This gave credibility to the finding that multiple factors were routinely explored, and that AAT was one important factor, among many, worthy of routine investigation with clients.

***Key finding 3: assessment procedures were collaborative and client-led; an appropriate context was necessary before AAT was explored, including engagement and a psychologically safe environment.***

The most common recommendation in the existing literature is that clinicians ought to routinely inquire about clients' trauma history. Suggestions that all service users should be asked about abuse during assessment are reasonable in principle, and potentially justified by the evidence linking early adversity and difficulties later in life. However, there is evidence suggesting that a large proportion of clients with abuse histories are never asked about their experiences by mental health staff in services; it is also uncommon that survivors of childhood abuse make spontaneous disclosures of their experiences (Elliott, 1997; Read *et al.,* 2006; Read *et al.,* 2007). If there was any systematic approach to assessment amongst the findings, in terms of using formal protocols, it was that participants collaboratively followed the client's lead. It is our opinion these principles of client readiness ought to be carefully considered when considering use of standardised trauma screening tools, such as the

Childhood Trauma Questionnaire. In the current study, there appeared to be a client-dependent principle guiding participants, and there were clear examples of situations whereby AAT would not be assessed, or at least not at that time, despite its potential relevance in clients' presentations. Examples included situations where distress or risk may be exacerbated, and where the client expressed a clear wish to avoid exploration of past traumas, instead focussing on 'here and now' or coping issues. A point of potential importance is the issue of internal barriers to asking about trauma and abuse. For example, Read *at al.* (2007) cite evidence of instances whereby clinicians' own fears about making inquiries affected their practice; they go on to suggest that learning about how to sensitively ask and respond may be warranted in some circumstances. However, the current study's participants were highly trained in carefully exploring these issues, and there were clearly circumstances in which this was explicitly not performed. This may raise the important issue of potential retraumatisation and could be considered relevant to a paradigm shift towards trauma-informed practice in mental health (Sweeney, Filson, Kennedy, Collinson & Gillard, 2018). Many clients with psychosis experience significant cognitive difficulties that can impact greatly on day-to-day and social functioning. Where issues are indicated, there is a role for neuropsychological assessment and consideration for cognitive remediation therapy in informing the above issues; these issues may also have a bearing on the potential timing and appropriateness of more trauma-focussed interventions (McCleery & Nuechterlein, 2019).

One may envisage a situation whereby a client's distress may be maintained by undisclosed AAT-related issues. It is possible that failing to inquire about AAT in this situation may inadvertently lead to the perpetuation of distress; however, continuing to ask could also cause distress and potential harm. Morrison (2009) suggests that routine inquiry into abuse history should be commonplace within mental health services. Changes were made to national CPA documentation over 10 years ago, which explicitly included the 'abuse question' (Department

of Health, 2008). The manner in which abuse-related information is obtained and recorded, and in what circumstances, is ultimately determined more locally. In the current study, factors such as client readiness were commonly deemed necessary in order to explore AAT explicitly. These additional factors are not essentially captured in straight-forward recommendations outlining the necessity of inquiring about abuse. Findings suggested that uncritically subscribing to a 'standardised' assessment protocol may in some situations risk distressing clients. An inherent complexity within this assessment issue relates to the question of what being 'asked about abuse' entails? There are differences between asking a relatively simple question, as in the CPA documentation, and actively inquiring about abuse history in the context of proposed links with psychosis, with the option of therapy.

### *Limitations*

The sample size of this study was small and this limits the extent to which findings may be applied to similar settings. The potential for self-selection biases must also be acknowledged with the recruitment strategy. Whilst the AAT focus was withheld from participants in the study advert, participant information sheet, and during parts A and B of the procedure, one cannot assume that the sample was representative of all clinical psychologists working in early psychosis. Finally, it should be acknowledged that the theoretical orientation of participants ought to be taken into consideration in future research investigating this topic. Indeed, clinician or training specific factors may play a role in determining how and when psychologists inquire about AAT in practice.

## Conclusion

The current findings are suggestive of heterogeneous clinical practices within the field of psychosis. Treating all clients the same is likely to compromise the likelihood of positive therapeutic outcomes, and both research and clinical approaches must continue to recognise the importance of individual differences. Of interest, the sample's assessment approaches appeared to be 'trauma-informed' but were not necessarily 'trauma-focussed'. The findings contribute to the literature in terms of helping further contextualise how and why clinicians ask about AATs, including, for instance, keeping in mind important factors such as risk and distress. Overly simplistic psychological and psychosocial approaches which suggest that 'trauma causes psychosis' may be insufficient; those who assume that stand alone factors sufficiently explain variance in clients' experiences of psychosis run the risk of focussing too narrowly on specific variables and may potentially neglect other important elements. However, with the case of AAT-related factors, and indeed the AAT construct itself, one risks broadening criteria to be so inclusive that specificity and meaningfulness are diminished. Part of the problem is that trauma is in the experience of the 'experiencer'; this can only be discerned by a clinician with a sufficiently inclusive perspective to recognise something as traumatic, rather than assuming that a given event will be so. This challenges fundamental ideas that events of a particular nature will be more likely to be experienced as traumatic.

Explicitly choosing not to address 'trauma' may be an important clinical decision in itself, for example if this is clearly against a client's wishes or if adaptive coping skills remain underdeveloped. This is a complex issue and there is a key role for clinical judgement in guiding responsible interventions. Clinicians have a duty of care towards their clients, and careful consideration of potential risks, including retraumatisation and psychological harm, are key parts of clinical practice. One of the key suggestions of the current study was that

participants appeared to operate within a more heterogeneous world than researchers may sometimes be willing to promote.

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*Table 1*: Key themes from part A and B data: 'To what extent does a sample of clinical psychologists working in early psychosis routinely investigate AAT with their clients?'

| | **Category** | **Core Idea** | **Proportion of sample** |
|---|---|---|---|
| **Assessment factors** | **Seeking AAT-related information** | Contextual information proximal to psychosis onset | 4/11 |
| | | Information regarding distal life events or early developmental context | 5/11 |
| | | Information relating to life events or clients' generic histories (without specifying life stages) | 6/11 |
| | **Seeking information, not explicitly AAT-related** | Contextual information proximal to psychosis onset | 9/11 |
| | | Information regarding distal life events or early developmental context | 11/11 |
| | | Information sought explicitly regarding clients' sense-making or appraisal of their experiences | 10/11 |
| | | Information relating to 'cognitive/schematic and/or emotional factors' | 9/11 |
| | | Information relating to relevant interpersonal factors and relationships | 9/11 |
| | | Information relating to wider 'social' issues including systemic/cultural factors | 6/11 |
| | | Information relating to clients' coping styles | 8/11 |
| | | Details relating to clients' strengths/values | 8/11 |
| | | Information on coping effectiveness | 5/11 |
| | | Information on biological or medical factors (including drugs and sleep deprivation) | 5/11 |
| | | Risk-related information | 4/11 |
| | | No routine procedure in practice – client-dependent approaches | 4/11 |
| | **Information gathering procedures, not explicitly AAT-related** | Routine procedure in practice | 3/11 |
| | | Seeking information allows formulation of clients' problems | 4/11 |
| | | Necessity to assess certain key factors | 4/11 |
| | | Guided by clinical judgement | 5/11 |
| | | Engagement and trust are necessary requirements | 4/11 |

*Table 2:* Key themes from part C data: 'To what extent does a sample of clinical psychologists working in early psychosis routinely investigate AAT with their clients?'

| Domain | Category | Core Idea | Proportion of sample |
|---|---|---|---|
| **Definitions and conceptualisations of AAT** | **Broad definitions of AAT** | Overarching message of heterogeneity – no simple way of conceptualising AAT | 7/11 |
| | **Developmental 'break'** | Resulting from a break in the expected developmental trajectory of a person's life, often in the context of significant life events. | 4/11 |
| | **AAT is distinctly negative** | AAT linked distinctly to negative experiences | 3/11 |
| **Assessment related themes (AAT related)** | **Inquiry warranted** | Central importance of assessing adversity | 9/11 |
| | **Specific information is sought** | Specific information regarding significant life events and impact on development | 7/11 |
| | **Collaborative inquiry** | Following client's lead as appropriate - a joint process | 7/11 |
| | **Context dependent** | Necessary context for in-depth AAT assessment – not always appropriate | 5/11 |
| | **Appropriate timing** | Wariness about conducting thorough inquiry too early in the process | 5/11 |
| | | The process is client-dependent | 4/11 |
| | **Clinical judgement** | Key role of clinical judgement - including MDT discussion where necessary | 3/11 |