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Abstract

Childhood trauma has long been recognised as a potential cause for a range of affective mental health problems arising in adulthood. Only in recent years has the association between childhood abuse and psychosis begun to be investigated. This paper provides a critical review of the literature addressing the relationship between childhood abuse and psychosis. Implications for practitioners are discussed, including practice, policy, treatment and child protection issues. A significant proportion of people develop psychosis in adulthood following all types of childhood abuse, including people diagnosed with schizophrenia, major depressive disorders, dissociative identity disorder and post-traumatic stress disorder. Evidence suggests the possibility of a causal relationship between childhood abuse and psychosis in adulthood. Mental health nurses are ideally placed to offer help, care and support to those individuals who experience psychosis by acknowledging and listening to their life events, including experiences of childhood abuse.

Keywords

childhood abuse, literature review, mental health, psychosis

Introduction

Research within the field of trauma has resulted in extensive evidence exposing a causal relationship between childhood abuse and various mental health problems, including anxiety and mood disorders (Cheasty *et al*., 1998; Swanston *et al*., 2003), eating disorders (Grilo and Masheb, 2002; van Gerko *et al*., 2005) and substance use (Spak *et al*., 1997; Kendler *et al*., 2000). Studies such as these tend to focus primarily on physical and sexual childhood abuse, minimising the devastating effects that emotional abuse and neglect may have upon a person's mental health (Read *et al*., 2003; Spataro *et al*., 2004; Kim *et al*., 2006; Shevlin *et al*., 2007).

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Despite such extensive evidence exploring relationships between childhood abuse and an array of mental health problems, the research relating to childhood abuse and psychosis is in its early stages (Hammersley, 2007). Until 2004, no large-scale studies addressed the possibility of a relationship between childhood abuse and psychosis; suggesting that this relationship remains controversial and understudied (Hammersley *et al*., 2004; Garno *et al*., 2005; Read *et al*., 2005). In 2005, Read *et al*. produced a literature review of relevant studies and previous review papers which suggests that psychosis is at least as related to childhood abuse as other diagnoses. The limited existing research suggesting a link between childhood abuse and psychosis therefore generates questioning surrounding the causative or contributory role of trauma in the development of serious mental health problems.

Aim of the study

Through a critical review of the literature, this paper examines the published research associating childhood abuse and psychotic experiences in later life. Figure 1 clearly sets out the main aims of the study.

Defining childhood abuse and psychosis

Within this critical review of the literature examining the relationship between childhood abuse and psychosis, the term 'childhood abuse' refers to childhood physical, sexual and emotional abuse, and neglect.

The term psychosis is used to refer to a range of experiences people may have that includes hallucinations (usually hearing voices) and unusual beliefs (often referred to as 'delusions'). These are inevitably considered as symptoms which are used by mental health professionals to categorise individuals into diagnostic groups. These groups, namely schizophrenia spectrum disorders, major depressive disorders, dissociative identity disorders (DID) and post-traumatic stress disorder (PTSD), will be referred to. However, these categories are a spectrum of possible responses to traumatic events and we do not

- To explore the relationship between all forms of childhood abuse and the experience of psychosis in later life;
- To explore the relationship between childhood abuse and specific diagnostic groups assumed to have a 'psychotic element' (schizophrenia spectrum disorders, major depressive disorders, dissociative identity disorders);
- To address the relationship between trauma, psychotic experiences, dissociative identity disorders and post-traumatic stress disorder;
- To identify how resilience, coping and individual differences may offer some explanation as to why not all people who have childhood abuse histories go on to experience psychosis in later life;
- To establish and explore the implications for professional practice.

Figure 1. Aims of the study

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subscribe to the necessity for the use of such diagnostic language other than for the study of the relevant literature and for communicating with the medical profession. Psychosis has historically been used as an umbrella term for a number of conditions and experiences. The notion of schizophrenia for example is a contested concept in the mental health literature. The concept of schizophrenia as a medical construct has been challenged in both the psychiatric and psychology arenas for at least the last 50 years (Laing, 1960; Szasz, 1961; Read *et al*., 2004). Medical language, therefore, used in this review does not reflect the conceptual position assumed by the authors, rather the language of research conducted in this area.

Traditionally, psychosis in general, and schizophrenia in particular, has long been assumed to have a *biological* or medical basis (Watkins, 2001; Boyle, 2002). For example, twin studies from a number of worldwide countries have played a pivotal role in establishing a genetic contribution to the etiology of schizophrenia (Cannon *et al*., 1998; Cardno *et al*., 1999; Cardno and Gottesman, 2000; Sullivan *et al*., 2003). Biological theories have, however, been criticised for their reductionist nature, and some regard them responsible for the inhumane treatment seen in psychiatry over the years, including the use of electroconvulsive therapy and psychotropic medications (Read *et al*., 2004). More recently, alternative explanations for the development of psychosis have begun to be acknowledged by the medical profession, and consequently a number of models now exist to explain the interaction between trauma and psychosis (Hammersley *et al*., 2008). Read *et al*. (2001) proposed their Traumagenic Neuro-developmental model of psychosis in which they suggested that childhood trauma could alter brain structure, and therefore that schizophrenia could result from long-lasting changes in the brain caused by childhood trauma. This suggests that whilst there may be some biological basis for the onset of psychosis, the differences in brain abnormality which are thought to exist in people who experience psychosis may be caused from adverse life events.

Childhood abuse and psychosis

The relationship between childhood abuse and psychosis has received limited attention until the turn of the 21st century (Hammersley, 2007; Morgan and Fisher, 2007) in spite of the possibility that 34–53% of people with serious mental health problems report a history of childhood sexual or physical abuse (Mueser *et al*., 1998). Additionally, amongst people using mental health services, people who have experienced childhood abuse are more likely to receive psychotropic medication, relapse more regularly and spend longer in inpatient settings (Read, 1998). Childhood abuse may be a predictor of psychotic experiences in later life, often occurring in a dose-response fashion, suggesting that psychosis worsens as the severity of abuse increases (Janssen *et al*., 2004; Schenkel *et al*., 2005). People with a history of childhood abuse who use mental health services are particularly likely to experience what are referred to as the positive symptoms associated with psychosis, for example hearing voices (Read and Argyle, 1999). Some important findings in this area have come from the work of Professor Marius Romme and Dr Sandra Escher, who have clearly identified a relationship between traumatic experiences, including childhood abuse, and voice hearing (Romme and Escher, 1989, 1993, 2006).

Method

Critical literature review

Within the health sciences, research is becoming increasingly important, with a focus being placed upon evidence-based practice (Ingersoll, 2000; Geddes, 2004; Rapport, 2004; Kelley

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et al., 2005). A literature review was the chosen method for this study as it allowed for the authors to condense the research in order to keep health care workers, researchers, consumers and policy-makers up to date with the evidence accumulating in the chosen field of expertise. The use of a critical literature review also fits more appropriately with the explorative nature of the study, and with the organic process it relies on (Greenhalgh and Peacock, 2005). Referring to a critical review as 'organic' denotes an untreated process which may progress and change as it develops. Critical literature reviews enable the researcher to assess topics broadly and are therefore suitable for examining wide bodies of evidence in a non-restrictive way, incorporating a breadth and depth of research. Cooper *et al.* (2005) argue that critical literature reviews may provide results of greater validity than a traditional literature review because of the way in which they are able to reflect the subjective views of the researcher. Writing in a critical manner also incorporates both a reflective and reflexive element to the study. Reflection involves showing ourselves to ourselves, whereas reflexivity involves the researcher's being conscious of one's self (Lipp, 2004). Reflexivity may bring together research and practice (Freshwater and Rolfe, 2001) and may prove useful in understanding the deeper meanings of the topics under review (Carolan, 2003).

Search strategy

The search process included several distinct phases. The primary source of data used to search the literature were the electronic databases Medline (OVID) and PsychInfo, chosen because of their relevance to the topic area. Three broad-based terms was applied as this can be effective in the identification of research from electronic databases (Fleming and Briggs, 2006; McKibbon *et al.*, 2006). The three search terms used were; 'childhood abuse', 'psychosis' and 'adulthood'. Searching OVID and PsychInfo using the search terms yielded 31 results, 17 of which were relevant. Using only the terms 'childhood abuse' and 'psychosis' yielded a total of 78 papers, only 5 of which were relevant and additional to the initial search. The second phase of the search aimed to include a broader range of literature and allow for a more diverse search (Petticrew and Roberts, 2006). Reference lists of the papers found were checked, from which a substantial amount of further papers were found. Thirdly, government reports, unpublished dissertations, thesis and books were searched for manually and used where appropriate. The review did not include first hand accounts of people's experiences of abuse, although these are also evident in the literature (e.g., Hurt, 1998; Stickley and Nickeas, 2006; Hammersley *et al.*, 2008). Finally, inclusion and exclusion criteria were used as a screening technique as this adds to the efficiency of a critical review and its relevance and accuracy (Fink, 2005). The total number of relevant papers retained following this final phase amounted to 72; these are listed in Table 1. The search criteria are shown in Figure 2.

Analysis of data

Criteria for analysing the literature were set with reference to the aims of the critical literature review. The papers were grouped into logical topics and subtopics, and then placed in chronological order within each of these. This facilitated the analysis of the data. Records were kept of methodological strengths and weaknesses, major trends or patterns, gaps in the literature, relationships existing between studies and how closely each paper relates to the

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Table 1. Findings

Author(s)	Focus/theme of discussion which the study relates to
Lowe (1973)	Major depressive disorders and childhood abuse
Freidman and Harrison (1984)	Schizophrenia spectrum disorders and childhood abuse
Figley (1985)	Resilience, coping and individual differences
Green *et al.* (1985)	Resilience, coping and individual differences
Kluft (1985)	Dissociative identity disorders and childhood abuse
Ellenson (1986)	Psychotic experiences and childhood abuse
Putnam *et al.* (1986)	Dissociative identity disorders and childhood abuse
Beck and van der Kolk (1987)	Schizophrenia spectrum disorders and childhood abuse
Goodwin and Jamison (1990)	Major depressive disorders and childhood abuse
Heins *et al.* (1990)	Psychotic experiences and childhood abuse
Ross *et al.* (1990)	Dissociative identity disorders and childhood abuse
Brown and Anderson (1991)	Schizophrenia spectrum disorders and childhood abuse
Goff *et al.* (1991)	Psychotic experiences and childhood abuse
Irwin (1992)	Psychotic experiences and childhood abuse
Pribor and Dinwiddie (1992)	Schizophrenia spectrum disorders and childhood abuse
Greenfield *et al.* (1994)	Schizophrenia spectrum disorders and childhood abuse
Ross *et al.* (1994)	Psychotic experiences and childhood abuse
Zimmerman and Arunkuma (1994)	Resilience, coping and individual differences
Kessler *et al.* (1995)	Trauma exposure, psychosis and PTSD
Polusny and Follette (1995)	Dissociative identity disorders and childhood abuse
Butler *et al.* (1996)	Trauma exposure, psychosis and PTSD
Miller and Finnerty (1996)	Schizophrenia spectrum disorders and childhood abuse
Allen *et al.* (1997)	Trauma exposure, psychosis and PTSD
Hamner (1997)	Trauma exposure, psychosis and PTSD
Joseph *et al.* (1997)	Dissociative identity disorders and childhood abuse
Bifulco *et al.* (1998)	Major depressive disorders and childhood abuse
Heller *et al.* (1999)	Resilience, coping and individual differences
Read and Argyle (1999)	Psychotic experiences and childhood abuse
Brewin *et al.* (2000)	Trauma exposure, psychosis and PTSD
Luthar *et al.* (2000)	Resilience, coping and individual differences
Bulik *et al.* (2001)	Resilience, coping and individual differences
Gleaves and May (2001)	Dissociative identity disorders and childhood abuse
McGloin and Widom (2001)	Resilience, coping and individual differences
Read *et al.* (2001)	Psychotic experiences and childhood abuse
Hirschfeld and Weissman (2002)	Major depressive disorders and childhood abuse
Kendler *et al.* (2002)	Major depressive disorders and childhood abuse
Kennedy *et al.* (2002)	Psychotic experiences and childhood abuse
Leverich *et al.* (2002)	Major depressive disorders and childhood abuse
Midgley (2002)	Dissociative identity disorders and childhood abuse
Neria *et al.* (2002)	Trauma exposure, psychosis and PTSD
Shaw *et al.* (2002)	Trauma exposure, psychosis and PTSD
Stein *et al.* (2002)	Trauma exposure, psychosis and PTSD
Berenbaum *et al.* (2003)	Psychotic experiences and childhood abuse
Hammersley *et al.* (2003)	Psychotic experiences and childhood abuse/major depressive disorders and childhood abuse
Holowka *et al.* (2003)	Dissociative identity disorders and childhood abuse

(continued)

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Table 1. Continued

Author(s)	Focus/theme of discussion which the study relates to
Morrison *et al.* (2003)	Trauma exposure, psychosis and PTSD
Read *et al.* (2003)	Psychotic experiences and childhood abuse/major depressive disorders and childhood abuse
Resnick *et al.* (2003)	Trauma exposure, psychosis and PTSD
Seedat *et al.* (2003)	Trauma exposure, psychosis and PTSD
Mueser *et al.* (2004)	Trauma exposure, psychosis and PTSD
Spataro *et al.* (2004)	Schizophrenia spectrum disorders and childhood abuse
Garno *et al.* (2005)	Major depressive disorders and childhood abuse
Goldberg and Garno (2005)	Major depressive disorders and childhood abuse
Kilcommons and Morrison (2005)	Dissociative identity disorders and childhood abuse
Muenzenmaier *et al.* (2005)	Trauma exposure, psychosis and PTSD
Read *et al.* (2005)	Schizophrenia spectrum disorders and childhood abuse
Sareen *et al.* (2005)	Trauma exposure, psychosis and PTSD
Schenkel *et al.* (2005)	Schizophrenia spectrum disorders and childhood abuse
Whitfield *et al.* (2005)	Psychotic experiences and childhood abuse
Foote *et al.* (2006)	Dissociative identity disorders and childhood abuse
Fleming and Richards (2006)	Trauma exposure, psychosis and PTSD
Jankowski *et al.* (2006)	Trauma exposure, psychosis and PTSD
Read *et al.* (2006b)	Psychotic experiences and childhood abuse
Romme and Escher (2006)	Schizophrenia spectrum disorders and childhood abuse/trauma exposure, psychosis and PTSD
Spauwen *et al.* (2006)	Major depressive disorders and childhood abuse
Stickley and Nickeas (2006)	Dissociative identity disorders and childhood abuse
Collishaw *et al.* (2007)	Resilience, coping and individual differences
Kastelan *et al.* (2007)	Trauma exposure, psychosis and PTSD
Sar *et al.* (2007)	Dissociative identity disorders and childhood abuse
Shevlin *et al.* (2007)	Psychotic experiences and childhood abuse
Ucok and Bikmaz (2007)	Schizophrenia spectrum disorders and childhood abuse

- Only English language studies have been included;
- No limit on date of publication;
- Studies investigating the relationship between childhood abuse and psychotic experiences in adulthood are included. Excluded are all studies predicting these effects;
- Excluded are studies that address other traumatic childhood events or mental health issues;
- Studies addressing childhood abuse and psychosis in adult participants are included;
- Excluded are studies which address childhood abuse and psychosis in participants who are of child or adolescent age.

Figure 2. Search criteria

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study, as recommended by Galvan (2006). The stage of analysing and comprehending is also where the process of reading and thinking critically plays a key role. Furthermore, the reflexive component of the critical literature review is an important element in the analysis of theory and concepts and enables formation of a more subjective view.

Findings

A summary of key findings has been included in Figure 3.

Psychotic experiences

In studies of people who use mental health services, the experience of hearing voices (auditory hallucinations), particularly voices that provide a running commentary, have been found to be the psychotic experience most strongly related to childhood abuse (Ross *et al*., 1994; Kennedy *et al*., 2002; Read *et al*., 2003). Heins *et al*. (1990) examined case-reports and from these proposed that hallucinations in people who experienced childhood abuse are not true hallucinations and instead are 'pseudo-hallucinations'. Heins *et al*. (1990) and Ellenson (1986) believe that true hallucinations, like those experienced in schizophrenia, are only present amongst incest survivors who use substances. Read and Argyle (1999) studied the records of 22 inpatients in which childhood physical or sexual abuse had been highlighted. The study found that none of the four female incest survivors were using substances, therefore discrediting Heins *et al*.'s (1990) and Ellenson's (1986) earlier claims. Hammersley *et al*. (2003) used a randomised, controlled trial of cognitive behavioural therapy in order for therapists to assess hallucinatory experiences in the participants, all of whom had a diagnosis of bipolar disorder. The findings reveal that auditory hallucinations were only slightly more common than visual hallucinations, with rates reported at 31% and 26% respectively. Whilst tactile hallucinations are uncommon, examination of the National Comorbidity Study highlighted that these exist for abuse types involving physical abuse and sexual childhood abuse (Shevlin *et al*., 2007). This indicates an association between the type of childhood abuse and the experience of psychosis

- A significant proportion of people appear to develop psychosis following all types of childhood abuse. Such abuse is increasingly being recognised as potential cause for psychosis in later life.
- Positive symptoms of psychosis, particularly commenting voices, appear to be most strongly correlated with childhood abuse.
- Experiences of psychosis following childhood abuse have been found to exist in people diagnosed with schizophrenia, major depressive disorders, DID, and PTSD.
- Some people who have been abused in childhood will not experience mental health problems later in life, this may be related to protective social factors although responses to trauma are not generalisable.

Figure 3. Summary of key findings

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in adulthood. The largest study to date, involving over 16,000 participants, used a self-report method to examine the relationship of childhood trauma to a history of hallucinations. The study found that childhood sexual, emotional and physical abuse all significantly increased the risk of hallucinations in later life (Whitfield *et al*., 2005). Childhood neglect was not directly measured; however, a range of adverse childhood experiences were included which may indirectly involve neglect towards the child.

What are referred to as negative psychotic symptoms may also be related to childhood abuse (Read *et al*., 2001). Additionally, some authors suggest that childhood abuse may be linked to specific psychotic experiences, including paranormal or peculiar beliefs (Irwin, 1992; Berenbaum *et al*., 2003) and unusual beliefs (more regularly referred to as delusions) (Goff *et al*., 1991; Read *et al*., 2003). Read *et al*. (2006b), however, have more recently discredited the possibility of a relationship between childhood abuse and what are referred to as negative symptoms, delusions and thought disorder.

Schizophrenia spectrum disorders

In their review of the literature, Read *et al*. (2005) concluded that childhood abuse is a causal factor in the development of schizophrenia. Evidence exists to support this view; however, there is also evidence to the contrary (Brown and Anderson, 1991; Pribor and Dinwiddie, 1992). Spataro *et al*. (2004), for example, contest the link between childhood sexual abuse and schizophrenia, stating that in their study no significant relationship was found. The method of this study was initially regarded to have high validity and reliability, as the sample size was large and reports of abuse were collected from official police, child welfare and child protection records. However, collecting data from official sources suggests that the children may have been removed from abusive environments, and received support and protection. Such safeguarding and psychological support may have prevented them from going on to experience psychosis in later life. In a prevalence study, Miller and Finnerty (1996) reported the occurrence of childhood abuse as 37% amongst patients diagnosed with schizophrenia spectrum disorders; they used a sample size of 20 women diagnosed with schizophrenia and 15 volunteers without a mental health diagnosis. Freidman and Harrison (1984) studied 46 women diagnosed with schizophrenia against a control group of non-psychotic volunteers. The incidence of reported sexual abuse was much higher in people diagnosed with schizophrenia, and this applied particularly to sexual abuse occurring in childhood. Through studying female inpatients experiencing psychosis, Beck and van der Kolk (1987) assert the possibility of a relationship between childhood incest and severe mental health problems. In two studies using retrospective self-report methods, high rates of childhood abuse have also been found in people diagnosed with first-episode schizophrenia (Greenfield *et al*., 1994; Ucok and Bikmaz, 2007). Schenkel *et al*. (2005) involved 40 inpatients diagnosed with schizophrenia spectrum disorders in semi-structured interviews which rated symptom presentation and severity. Association was found between childhood abuse and earlier age of hospitalisation, increased hospitalisations and greater levels of depression and suicidality. This study was the first of its kind to systematically investigate the type, severity, frequency and age of onset of the childhood abuse. In research with people who hear voices, Romme and Escher (2006) found that in 77% of those diagnosed with schizophrenia the voice hearing was related to traumatic experiences, including all forms of childhood abuse.

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Major depressive disorders

Childhood abuse has long been recognised as a risk factor for depression (Hirschfeld and Weissman, 2002). Childhood sexual abuse has been strongly correlated with depression (Kendler *et al*., 2002). Childhood abuse and neglect have been associated with early onset depression (Bifulco *et al*., 1998). A more contested relationship is that between childhood abuse and depression and psychotic experiences. Psychosis is common amongst people diagnosed with bipolar affective disorder. In a review of 20 studies investigating the prevalence of hallucinations in bipolar disorder, Goodwin and Jamison (1990) calculated this prevalence to be as high as 18%. Hallucinations in bipolar affective disorder have been thought to be brief, and less real and controllable than those experienced in schizophrenia (Lowe, 1973). However, hearing critical voices was strongly correlated with childhood sexual abuse in people diagnosed with bipolar disorder (Hammersley *et al*., 2003), consistent with research exploring psychotic experiences in schizophrenia (Read *et al*., 2003). People diagnosed with bipolar disorder who have experienced childhood abuse have been found to have worse outcomes than non-abused counterparts, including earlier age of onset, more severe course of illness, more manic or depressive episodes, increased suicide attempts and higher incidence of substance use (Leverich *et al*., 2002; Goldberg and Garno, 2005; Garno *et al*., 2005). Conversely, Spauwen *et al*. (2006) collected self-reports on psychological trauma and psychosis proneness, and at follow-up interviewed participants for the presence of psychotic symptoms. They found no association between major depressive disorders and childhood abuse, proposing that there may be a more specific link with disorders displaying more severe psychotic symptoms, such as schizophrenia.

Dissociative identity disorder

Controversy has long surrounded the diagnosis of DID (Stickley and Nickeas, 2006). However, it is now considered to be more prevalent than previously conceived in both general and service user populations (Ross *et al*., 1990; Foote *et al*., 2006). Two theories offer possible causes for DID; traumagenic and iatrogenic factors (Gleaves and May, 2001). Traumagenic causes involve childhood trauma, whilst the iatrogenic debate believes that media influence and psychotherapeutic inference cause DID. Arguing from a traumagenic position, evidence supports the theory that DID occurs in conjunction with severe childhood trauma (Kluft, 1985; Putnam *et al*., 1986; Sar *et al*., 2007). DID is often regarded as an associated feature of childhood sexual abuse (Polusny and Follette, 1995; Joseph *et al*., 1997; Midgley, 2002). Furthermore, research from two studies, one a prevalence study, the other using self-report questionnaires, both strongly correlate childhood emotional abuse to dissociation in people with psychosis (Holowka *et al*., 2003; Kilcommons and Morrison, 2005).

From studying a general population sample in Turkey, Sar *et al*. (2007) believe all childhood abuse types are significant predictors of dissociative disorders. Other authors hotly contest such an association (Piper and Merskey, 2004). In people diagnosed with schizophrenia, those individuals with increased dissociative symptoms had more severe trauma histories (Spitzer *et al*., 1997; Ross and Keyes, 2004). Hearing voices is common in DID (Ross *et al*., 1990), particularly ones of a punitive and hostile nature (Honig *et al*., 1998). Such evidence suggests that dissociative experiences may be a common traumatic reaction, and overlap may exist between the experiences of DID and schizophrenia. However, dissociation is not listed as a symptom for psychosis within the DSM-IV (APA, 1994), nor

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are hallucinations recognised within dissociative disorders. De Zulueta (2002) carried out a prospective study of 161 women who had recently been a victim of assault and found dissociative experiences to be associated with PTSD, further suggesting a relationship between dissociation and traumatic events. Similarities exist between dissociation and PTSD, including alteration in memory, identity and consciousness (Feeny *et al*., 2000).

Trauma exposure, psychosis and PTSD

Increasingly, traumatic symptoms are being found to occur alongside psychosis (Fleming and Richards, 2006). A number of people diagnosed with serious mental health problems appear to experience co-morbid PTSD (Neria *et al*., 2002; Romme and Escher, 2006). This association implies that traumatic experiences may play a role in the causation of psychosis in later life, a standpoint opposing traditional views that psychosis arises purely from biological factors. Rates of PTSD among 782 people diagnosed with schizophrenia have been reported to be as high as 28–29% (Mueser *et al*., 2004). This is in comparison with an estimated lifetime prevalence of 7.8% in the general population (Kessler *et al*., 1995).

Several explanations for the link between trauma exposure, psychosis and PTSD exist. Firstly, there may be a causal relationship. Traumatic experiences may lead to co-occurring PTSD symptoms and psychosis in later life (Muenzenmaier *et al*., 2005). In contrast, individuals who have experienced childhood abuse and later develop psychosis may encounter additional traumatic events during their psychotic episode (Shaw *et al*., 2002), including hospitalisation or receiving a metal health diagnosis. Therefore PTSD may succeed the presentation of psychosis because of additional traumatising experiences. Another argument is that people with previous or current mental health problems are at increased risk of developing PTSD compared with the general population (Brewin *et al*., 2000). Risk factors include genetic and environmental characteristics or personality traits that predispose people to PTSD (Stein *et al*., 2002). Psychosis may increase the likelihood of trauma occurring because of related correlates including poverty, homelessness and substance use (Jankowski *et al*., 2006). This is consistent with findings from a sample of people with severe mental health problems that reported higher rates of PTSD in unemployed and homeless participants (Mueser *et al*., 2004).

Psychosis may present as co-morbid with PTSD and may worsen the outcome of severe mental illness (Resnick *et al*., 2003). Additionally, PTSD and psychosis may share similarities in the symptoms they display (Allen *et al*., 1997). This highlights the possibility that psychosis and PTSD exist on a spectrum of responses following trauma (Morrison *et al*., 2003). Evidence suggests that it is not uncommon for people with severe PTSD to experience hallucinations or unusual beliefs (Butler *et al*., 1996; Kastelan *et al*., 2007), and that this can be unrelated to another mental health problem (Seedat *et al*., 2003). Alternatively, it has been argued that people with PTSD do not experience hallucinations in the same way as people experiencing psychosis. In PTSD, it may be that re-experiencing phenomena such as flashbacks are the psychotic-like symptom (Hamner, 1997). Butler *et al*. (1996) argue that hallucinations and delusions differ from the experience of recurring events in people with PTSD, and that in some cases this is unrelated to the original trauma. Sareen *et al*. (2005) further argue that the PTSD re-experiencing cluster of symptoms differs from psychosis, therefore supporting the existence of psychosis in PTSD.

Having described both DID and PTSD, it is important to recognise where these conditions overlap, especially, for the sake of this study, in relation to childhood abuse.

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Naturally, not everyone who receives a diagnosis of PTSD has experienced childhood abuse; however, they may experience subsequent problems such as psychosis that may be identical to the experiences of someone who dissociates. Furthermore, the experiences of dissociation may be regarded as a manifestation of psychosis. The potential for these overlaps therefore indicates the potential for misdiagnosis by the medical profession, especially amongst those who have experienced childhood abuse.

Resilience, coping and individual differences

Although childhood abuse may be a causal factor in relation to psychosis, a number of individuals progress throughout life without developing adverse psychosocial or mental health problems despite experiencing severe childhood trauma (Collishaw *et al*., 2007). In a sample of people with a history of childhood abuse, McGloin and Widom (2001) classified 22% as 'resilient'. Resilience requires an individual to function competently despite exposure to childhood abuse (Heller *et al*., 1999). A major criticism of the study of resilience is that it is unclear whether all of the participants have experienced similar levels of adverse experiences to begin with (Luthar *et al*., 2000). In terms of childhood abuse, several factors appear to be consistently related to resilience: good relationship experiences (Collishaw *et al*., 2007), whether or not once the abuse was reported the abuse ended, and how severely the child was affected during the abuse (Bulik *et al*., 2001). Zimmerman and Arunkuma (1994) argue against the study of specific protective factors, as these may interlink and therefore it is unclear which factor is related to resilience. Green *et al*. (1985) propose a working model of reactions to trauma. The model proposes that individual characteristics, understanding of experiences, and dealing with these experiences, as well as the social environment, all play a role in determining the psychological outcome. This model therefore takes an individual approach to examining reactions to trauma, and is supported by Figley (1985), who believes that individual variations exist in human reactions to the same trauma.

Implications for professional practice

Asking about abuse histories

It has been asserted that statutory mental health professionals rarely ask about abuse and this often results in unidentified cases (Lothian and Read, 2002). Practitioners whose beliefs lie in biological and genetic causes of mental health problems are even less likely to ask about childhood abuse (Young *et al*., 2001; Read *et al*., 2007). It is also asserted that people experiencing psychosis are the least likely to be asked about abuse histories, and are less likely to receive a response once abuse is disclosed in comparison with people diagnosed with other mental health problems (Read and Fraser, 1998; Agar and Read, 2002). Additionally, emotional abuse is recognised less often by professionals than other abuse types (Thompson and Kaplan, 1999). In a study of sexually abused participants, only 22% of those involved with mental health services had been asked about previous abuse (Read *et al*., 2006a). Sixteen years has been found to be the average amount of time taken to disclose childhood abuse (Read *et al*., 2006b).

Whitfield *et al*. (2005) suggest that mental health workers have a responsibility to obtain childhood abuse histories where hallucinations have previously been, or are currently being, experienced. It is asserted that mental health nurses should become aware of childhood

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abuse histories in order to assist in conceptualising and contextualising a person's problems and to help identify appropriate interventions. Lothian and Read (2002) found 69% of service users connected their mental health problem to previous abuse; of these, only 17% felt that their clinician believed in this connection. People may be less likely to divulge information about childhood abuse where they feel that such disclosure will be dismissed by clinicians.

Policy and training

It has been observed that mental health professionals are more likely to be successful when asking about abuse histories and in responding to abuse disclosure if they have received adequate training (Read and Fraser, 1998; Gallop, 1999). Recognising childhood abuse allows professionals to plan care that is relevant to the person's past experiences of abuse and current experiences of psychosis. Through the development of policy and procedures in terms of asking about abuse, responding to histories of abuse and following up such information, mental health nurses may benefit people using services. Agar *et al*. (2002) suggest that it may not always be appropriate to ask about childhood abuse, particularly where a person is in crisis. Policies highlighting how and when to ask about childhood abuse and what to do if somebody discloses abuse may better equip mental health nurses to deal with such situations. Furthermore, there are those who have developed guidance for training to ask about abuse (Gold, 1997; Read *et al*., 2007).

Approaches, treatments and intervention

Conventional methods of treating the symptoms assumed to be part of a psychotic illness, such as hearing voices, have tended to focus on the use of medication. Such treatment is likely to be helpful for some individuals, however for some people, such anti-psychotic medication does not remove the symptoms and can prevent the emotional processing and healing of the meaning of the voices (Romme and Escher, 2006). For effective treatment and intervention, mental health professionals, it is argued, need to understand the reasons behind a person's presentation. Read *et al*. (2003) argue that treatment models addressing the needs of people who experience psychosis following trauma have only recently begun to emerge. Cognitive behavioural therapy (CBT) has proved effective in treating psychosis following trauma and is relatively quick and easy to train practitioners to use (Kingdon and Turkington, 2002). A CBT approach may help people recognise the relationship between past trauma, current thought process and their psychotic experiences.

A combination of cognitive interventions alongside psychodynamically orientated trauma-focused therapy has also proven to be successful in reducing psychotic experiences (Read and Argyle, 1999; Paley and Shapiro, 2002). This, however, has become contentious (Tarrier *et al*., 2002). It is argued that treatment should be based upon the experiences of the person in a way which is meaningful to them. Hawkins (2005) proposes a person-centred approach to therapy for those who have experienced childhood trauma and that the therapeutic relationship should be both necessary and sufficient for healing and growth. The seminal research in Holland conducted by Marius Romme and Sandra Escher (Romme and Escher, 1993) is of great significance here. Their more democratic approach to hearing voices focuses more upon self-help and peer support and less upon the need for professionally trained experts.

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Child protection issues

Professionals in contact with children have a duty to acknowledge and care for children who may experience psychosis as a result of abuse experiences. Escher conducted research with children hearing voices, following 82 children over a period of four years (Romme and Escher, 2006). Within this four year period 64% of the children's voices disappeared through learning to cope with emotions and alleviating stress. The children whose voices were diagnosed as being part of a psychiatric illness appeared to receive less attention and the voices became worse, resulting in delayed development for these children. Such research highlights the need for professionals to acknowledge the psychosocial issues which children may be dealing with, and suggests that medicalising such experiences at a young age may be extremely damaging and detrimental to a child's health and well being.

Furthermore, many people using mental health services are parents, or come into contact with children. Mental health professionals therefore should be actively involved in monitoring and protecting children in order to prevent future generations from developing psychosis following childhood abuse. Whilst the majority of people with mental health problems do not abuse their children, studies have suggested a link between parental mental health problems and childhood abuse (Bland and Orn, 1986; Walsh *et al.*, 2002; Barlow and Underdown, 2005). It may be that parents with mental health problems find it difficult to cope when looking after their children, especially when facing acute distress or crisis. This may result in abuse towards the child, either of an intentional or unintentional nature. Nurses, therefore, need to ensure that service users are assessed and any potential risks to children are documented. Whenever there are issues of concern, child protection policies and procedures should be consulted and followed (Stower, 2000). In the UK, a policy document, *What To Do if You're Worried a Child is Being Abused* (Department of Health, 2003), summarises key processes in dealing with possible childhood abuse.

Conclusion

Increasingly childhood abuse is being recognised as a potential cause of psychosis; however, still only a limited amount of well-designed studies exist. This review has revealed the alarmingly high prevalence of childhood abuse within both service-user and general population samples, and has suggested that childhood abuse causes suffering and distress which may lead to adverse outcomes in later life (Nelson *et al.*, 2002; Rosenberg *et al.*, 2007). The findings demonstrate that mental health care may be failing to recognise the needs of some people experiencing psychosis. The study has also highlighted that psychosis and PTSD may occur alongside one another following childhood abuse (Kilcommons and Morrison, 2005). They may be similar entities, existing as part of a spectrum of possible reactions to trauma (Larkin and Morrison, 2006).

A number of the studies included within this paper use self-report as a measure of childhood abuse. Retrospective reporting of childhood abuse, particularly from people with psychotic experiences, presents a methodological problem, as mental health may impact on recall (Morgan and Fisher, 2007). However, despite the criticisms of using retrospective self-reports, many authors generally recognise the reliability of using this method (Fergusson *et al.*, 2000; Read *et al.*, 2005). Moreover, childhood abuse studies often focus on female samples, limiting gender comparisons and potentially disregarding the impact of childhood abuse upon male participants. Childhood abuse may be much more prevalent than recognised within male service user populations. Childhood abuse may

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involve more than one type of abuse, and may also arise from a nexus of adversity; therefore, mediating factors may increase the severity of psychotic symptoms. There is a need for more studies controlling for possible mediating factors as well as more methodologically controlled, well-designed, large-scale studies addressing childhood abuse and psychosis. This study has highlighted the need to challenge bio-medical explanations of psychosis; this may be easier to achieve conceptually than practically as the bio-medical model continues to dominate in mental health care.

Mental health nurses need to be challenged in order to re-think the current understanding and treatment of people who experience psychosis. Whilst there is much scope for psychotherapeutic approaches for people who have experienced abuse and trauma, alternative approaches such as those advocated by the Hearing Voices Network might be more appropriate in some situations. Furthermore, the significance of the therapeutic relationship should not be understated. Through listening to people's stories, and offering care and support, practitioners have the potential to help people to find healing from the traumas they have experienced.

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