

Child Sexual Abuse and Delusions

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Overview

Part 1 constitutes a review of the literature relating to child sexual abuse (CSA) and delusions. There is evidence to suggest that CSA is related to psychotic symptoms and diagnoses of schizophrenia, and some authors have found thematic links between the nature of abuse and the content of psychotic symptoms. A wide range of biopsychosocial factors have been postulated in the literature as mediating or moderating the relationship between childhood abuse and psychotic symptoms in adulthood. However, despite the consistently demonstrated relationship between child abuse and adult psychopathology, research suggests that the majority of abuse is unidentified by mental health services in routine clinical practice.

The empirical study which forms Part 2 uses a mixed quantitative and qualitative methodology to explore the relationship between child sexual abuse, schemas and delusional content in a sample of 16 adult psychiatric patients. Participants were interviewed and completed a number of standardised assessment tools to create vignettes for each participant. These vignettes were sent to two external panels of experts in formulation in psychosis, who were unable to make links between the vignettes at a rate above chance. The researcher conducted a thematic analysis which extracted five main themes from the delusions of the CSA participants.

Part 3 is a critical review of the research process which examines the key decisions and issues raised during the study in more depth. It also considers the relationship between participant and researcher, and the wider context in which the study took place. It examines the study in the light of guidelines for evaluating the quality of qualitative research.

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**Child Sexual Abuse and Delusions:
A Literature Review**

Part 1

Child Sexual Abuse and Delusions

A Literature Review

Abstract

There is a considerable body of research demonstrating that childhood sexual abuse (CSA) is associated with widespread short- and long-term psychopathology, and moreover, is connected with the most severe, chronic and life-threatening consequences of a wide range of psychiatric disorders. More specifically, there is a growing body of evidence reporting that CSA is related to psychotic symptoms and diagnoses of schizophrenia, and some authors have found thematic links between the nature of abuse and the content of psychotic symptoms. A wide range of biological, psychological and social factors have been postulated in the literature as mediating or moderating the relationship between childhood abuse and psychotic symptoms in adulthood. Cognitive models of psychosis, and delusions in particular, are increasingly influential. There is ongoing debate as to the nature of the relationship between childhood abuse and psychosis, with some theorists proposing a causal relationship. Despite the consistently demonstrated relationship between child abuse and adult psychopathology, research suggests that the majority of abuse and trauma is unidentified by mental health services in routine clinical practice. Clinical issues related to enquiring about abuse are examined.

Introduction

It has been estimated that one-fifth to one-third of adult women have been sexually abused as children (Briere & Runtz, 1986) and evidence suggests that this rate is far

higher among psychiatric patients than the general population. There is a large body of research which suggests that child sexual abuse (CSA) is associated with widespread short- (Beitchman, Zucker, Hood, DaCosta, & Akman, 1991) and long-term psychopathology (Beitchman et al., 1992; Briere & Runtz, 1993; Browne & Finkelhor, 1986). Research also suggests that there is a strong relationship between psychotic disorders and childhood abuse, though it does not necessarily claim a causal one. A recent prospective study of a population sample of 4045 participants, found that child abuse predicted psychotic symptoms in adulthood (Janssen, Krabbendam, Bak, Hanssen, Vollebergh, de Graaf, and van Os, 2004). However, despite the consistently demonstrated relationship between child abuse and adult psychopathology, research suggests that the majority of abuse and trauma is unidentified by mental health services in routine clinical practice (Young, Read, Barker-Collo & Harrison, 2001).

This review will investigate the association between child abuse and adult psychotic disorders, focusing on the relationship between CSA and delusions. It will start by examining the prevalence of CSA in clinical populations and consider some of the methodological issues in investigating this area. It will outline some of the theoretical accounts of individuals' responses to CSA and examine the factors that may moderate and mediate the influence of CSA on subsequent disorders. The review will also address the association between CSA and varied adult psychopathology. It will then examine the specific relationship between CSA and psychotic disorders both in terms of diagnostic categories as well as from a symptom-focused perspective. It will conclude by exploring some of the possible

explanations for the low rates of abuse identified in clinical practice, with particular emphasis on psychosis.

Prevalence

The true prevalence of CSA in clinical populations can be difficult to ascertain as clinicians frequently fail to take abuse histories (Briere & Zaidi, 1989; Read & Fraser, 1998b; Rose, Peabody, & Stratigeas, 1991; Wurr & Partridge 1996). Therefore studies based on review of medical records or interviews with the clinician probably underestimate the true abuse prevalence rates of a sample. In addition, evidence suggests that inpatients tend to underreport abuse (Dill, Chu, Grob, & Eisen, 1991), so even rates based on patient self-report may be underestimates. Bearing this in mind, in a review of 15 studies totalling 817 inpatients, Read (1997) calculated that 64% of women inpatients reported either childhood physical abuse (CPA) or CSA. CSA was reported by 50% of the women, CPA was reported by 44% and 29% reported both physical and sexual abuse. Reporting a similar rate, Beck and van der Kolk (1987) reviewed in-patient records and interviewed staff and found that 46% of their sample reported CSA. In a study of 66 female psychiatric inpatients using self-report questionnaires, Bryer et al. (Bryer, Nelson, Miller, & Krol, 1987) found that three-quarters of their 68 participants had been physically and/or sexually abused at some time during their lives. Friedman and Harrison (1984) found that among women inpatients diagnosed with schizophrenia, 60% had suffered CSA. These studies are limited by the self-selecting nature of sampling, requiring as it must, informed consent, which probably excludes more disturbed (and potentially highly abused) individuals. As a consequence almost all figures are probably underestimates of 'true' population-wide prevalence. Most recently, Spataro and

colleagues found a fourfold increase in contacts with mental health services in people with CSA as compared with the general population (Spataro, Mullen, Burgess, Wells, and Moss, 2004).

Male inpatients tend to report similar rates of CPA but lower rates of CSA than female inpatients (Jacobson & Richardson, 1987). Differences for sexual abuse among inpatients have been reported as 38% female versus 24% male (Sansounet-Hayden, Haley, Marriage, & Fine, 1987), 52% versus 39% (Wurr & Partridge, 1996), and 54% versus 26% (Jacobson & Herald, 1990). Rates of CSA in male inpatients tend to be at least double the rates of CSA in the general male population (Palmer, Bramble, Metcalfe, Oppenheimer, and Smith 1994).

What might be the consequence of CSA in those receiving psychiatric help? The evidence suggests that when compared to non-abused patients, abuse survivors enter psychiatric hospital at a younger age (Darves-Bornoz, Lemperiere, Degiovanni, & Gaillard, 1995), have longer and more frequent hospitalisations (Rose et al., 1991; Sansounet-Hayden et al., 1987), spend more time in seclusion (Beck & van der Kolk, 1987), are more likely to receive psychotropic medication (Briere & Runtz, 1988; Bryer et al., 1987; Sansounet-Hayden et al., 1987), relapse more frequently (Goff, Brotman, Kindlon, Waites, et al., 1991) and are more likely to attempt suicide and deliberately self harm (Beitchman, et al., 1992; Briere & Runtz, 1988; Brown & Anderson, 1991; Darves-Bornoz et al., 1995; Rose et al., 1991; Sansounet-Hayden et al., 1987). A New Zealand study of 200 adult outpatients found that CSA was a stronger predictor of current suicidality than a current diagnosis of depression (Read, Agar, Barker-Collo, Davies and Moskowitz, 2001a). After controlling for factors

related to disruption and disadvantage in childhood, a community survey found that New Zealand women for whom CSA involved intercourse were 12 times more likely than non-abused females to have had psychiatric admissions (Mullen, Martin, Anderson, Romans & Herbison, 1993). Thus there is strong evidence that childhood abuse, and perhaps CSA in particular, has long-lasting detrimental effects on mental health in general, and tends to associate with the most severe, chronic and life-threatening consequences of a wide range of psychiatric disorders.

Methodological Issues

Notwithstanding this conclusion, the literature is characterized by a number of limitations. Those that apply to many of the studies reviewed will be highlighted in this section.

Studies are often limited by the use of small samples and/or samples which are limited in diagnostic mix. In their review, Wexler et al. (1997) found only three studies which included more than 100 patients (Wexler, Lyons, Lyons, Mazure, 1997). Of these, one drew patients from an outpatient clinic treating individuals who were employed or students, thus under-representing the more severe and enduring disorders (Swett, Surrey, & Cohen, 1990). The second only included patients being treated in an anxiety disorders clinic, hence restricting the diagnostic range (Mancini, Van-Amerigen and MacMillan, 1995). The third included 947 inpatients, but less than 10% had a diagnosis of schizophrenia and only 5% had major depressive disorders, consequently limiting the ability to detect possible association between abuse and either of these disorders (Brown & Anderson, 1991), and again suggesting the exclusion of more severe psychopathology. Perhaps what is called for is both

inpatient and outpatient studies that are both extensive and representative, enabling greater certainty about both comparative rates and potential relationships with demographics and psychopathology.

Data is often collected using one method such as self-report, review of medical records, or interviews with a clinician. Each method involves a level of bias, for example relying on records rather than asking patients can lead to underestimates of abuse. Ideally, studies should use multiple measures that include more objective methods, such as interview-based measures combined with self-report.

Studies into CSA are often poorly controlled. In their review, Beitchman et al. (1991) found that only 7% of studies used both clinical and normal controls simultaneously. In addition, until recently the huge majority of studies have only looked at women.

There are also huge inconsistencies in the operational definitions of childhood sexual abuse varying from 'no contact abuse' or 'any unwanted sexual experience' to 'contact abuse including genital fondling or penetration'. This creates difficulties in comparing findings across different studies. The generalisability of the studies' findings could also be improved by ensuring that clinical samples are well-defined and that diagnoses are made using valid and reliable methods (such as the structured clinical interview for DSM-IV), and ideally, randomly selected.

The vast majority of studies are retrospective, and can be limited in their accuracy by the availability of relevant memories to the patients and by their willingness to

discuss events that they may have kept secret for years. Most studies do not corroborate reports of abuse in childhood, which raises the issue of the validity of abuse disclosures. However, Dill et al. (1991) have found that abuse disclosures by psychiatric patients are reliable and that patients tend to underreport abuse histories rather than over report them. Darves-Bornoz et al. (1995) found that patients with a diagnosis of schizophrenia were no more likely to make incorrect allegations of sexual abuse than the general population. As yet, there are very few long-term prospective studies, however, two recent studies have used prospective methodology (Spataro et al., 2004; Janssen et al., 2004). Spataro and colleagues demonstrated an association between CSA ascertained at the time, and a subsequent increase in the rate of adult mental disorders. It is important to note that the average age of participants in this study was in the 20s, and it may not, therefore, have fully incorporated people who are yet to develop psychosis and other disorders that may have a later onset. Janssen and colleagues (2004), as part of the Netherlands Mental Health Survey and Incidence Study (NEMESIS), used prospective methodology in a large general population sample of 4045 participants and found that early childhood trauma increases the risk for positive psychotic symptoms. However, the authors acknowledge that measurement of reported child abuse was not very refined, and the small number of participants reporting abuse meant the unique effects of emotional, physical, and sexual abuse could not be assessed. In addition, the study only focused on positive symptoms of psychotic experiences; the other dimensions of psychosis, for example negative symptoms, were not assessed.

These limitations do not invalidate the findings, but one should be cautious in interpreting the results of an individual study.

The association between child sexual abuse and adult psychopathology

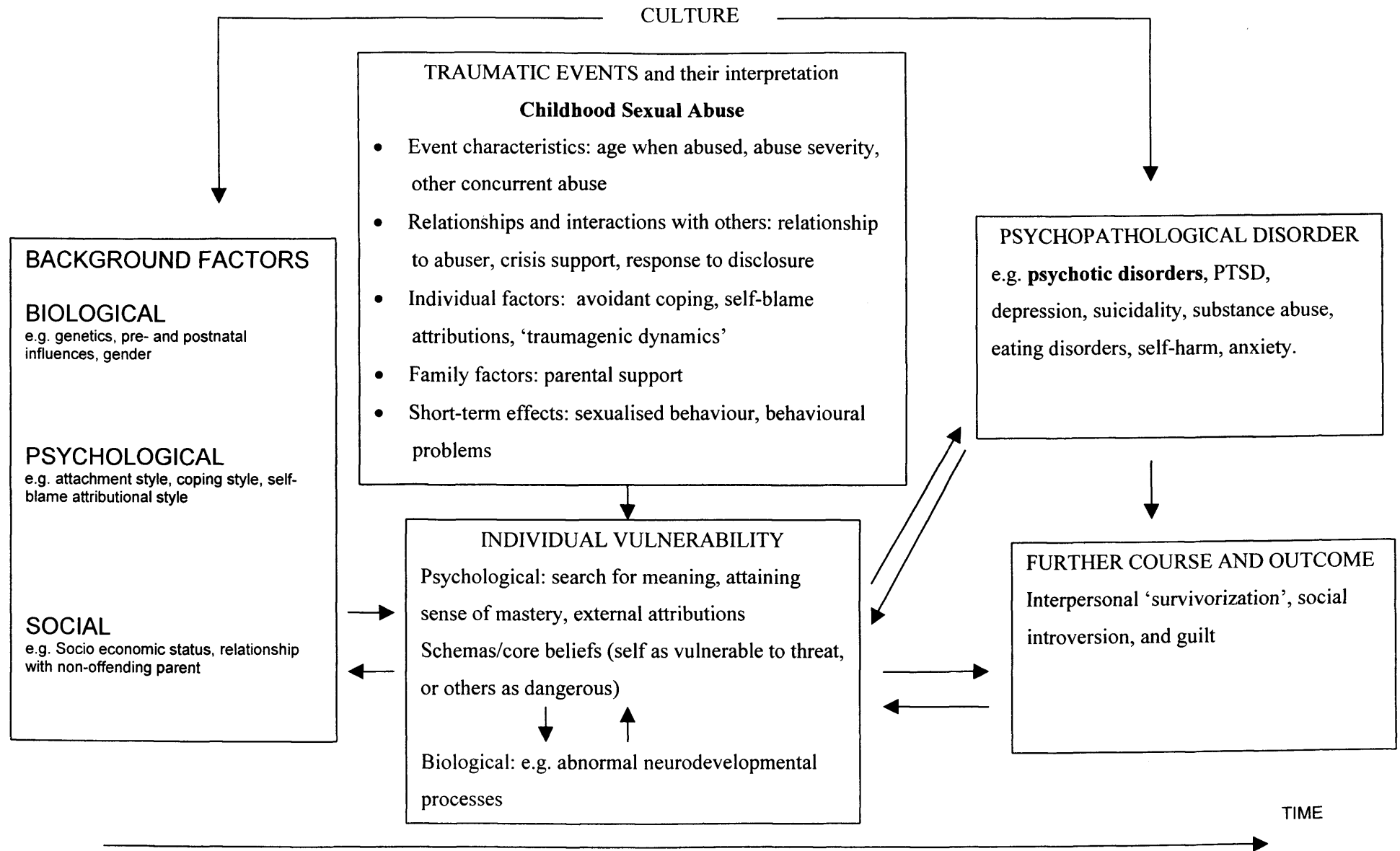
Models of response to trauma

Figure 1 (From Perris, 1998) is a working model which aims to incorporate the many and varied factors postulated in the literature as influencing the relationship between CSA and adult psychopathology. It suggests that background factors such as genetics, attachment style, and socio-economic status, which are present before CSA begins, result in a vulnerability to future psychopathological disorder. This psychological and/or biological vulnerability is exacerbated by the CSA experience, which is seen in terms of event characteristics (such as abuse severity), relationships with others, individual factors (such as self-blame attributions), family factors and the short-term effects of the abuse (such as sexualised behaviour). The abused individual is, in this way, more likely to experience psychopathological disorder in adulthood, for example psychosis.

A number of other theoretical accounts of the effects of CSA have been suggested in the literature. For example, Wyatt and colleagues highlight the importance of external attributions of blame (Wyatt, Newcomb, & Knotgrass, 1991). They evaluated the interrelationships between moderators and mediators of women's reactions to sexual abuse and proposed four moderators (age of survivor at latest abuse, severity of abuse, maximum number of rapes per incident, proximity of the perpetrator to the survivor), and three mediators (response to confiding, involvement of authorities, internal attributions/self-blame).

Draucker's (1995) model suggests that attaining a sense of mastery and meaning is predictive of more positive outcomes. This model is based on Finkelhor & Browne's

Figure 1: Model of response to Childhood Sexual Abuse (From Perris, 1998. All amendments author's own)



(1985) 'Traumagenic Dynamics Model of Child Sexual Abuse' in which it is proposed that traumagenic dynamics 'alter children's cognitive and emotional orientation to the world, and create trauma by distorting children's self-concept, world view, and affective capacities' (Finkelhor and Brown, 1985, p. 531). They highlight four variables thought to be of key importance: Stigmatization caused by the negative connotations of abuse e.g. badness, shame, and guilt; betrayal, where the child finds that someone on whom they were dependent has caused them harm; powerlessness, where the child's desires and sense of efficacy are contravened; and traumatic sexualization, where developmentally inappropriate sexual feelings/attitudes arise. Draucker (1995) suggests that the impact of these four variables (betrayal, powerlessness, traumatic sexualisation and stigma) is mediated by two cognitive tasks thought to influence coping (search for meaning and attaining a sense of mastery). According to Draucker's model, the interaction between the four starting variables and two mediating tasks contributes to individual variation across three outcome variables (interpersonal 'survivorization', social introversion, and guilt).

Barker-Collo and Read (2003) have proposed that the factors influencing outcome fall into 3 main categories: event characteristics/context; relationships and interactions with others; and characteristics of the individual. In considering contextual factors, they suggest that abuse at a younger age, more severe abuse and the presence of other forms of abuse and neglect lead to more negative outcomes. Relationship factors include the relationship of the CSA survivor to the perpetrator, crisis support and responses of others to disclosure. There is some empirical support for this account in that negative outcomes are associated with close proximity of the

perpetrator, involvement of authorities, engagement of crisis support, and the presence of anxious and/or avoidant attachments. In terms of individual characteristics, self-blame attributions and use of emotion-focused coping strategies are associated with poorer outcomes.

In their discussion of models of response to CSA, Barker-collo & Read (2003) point out that these earlier models are limited by their focus on moderators and mediators that are not modifiable by clinical intervention (e.g. age at onset), and the difficulty in measuring key concepts (e.g. sense of betrayal). Current thinking indicates a wide range of personal, cognitive, social and environmental factors as mediators and moderators of individuals' reactions to trauma, for example Joseph et al's (1995) integrative cognitive-behavioural model of posttraumatic stress disorder (Joseph, Williams, and Yule, 1995). Barker-collo and Read (2003) suggest that by and large, CSA can be viewed within the general trauma and PTSD literature.

Short-term effects

There is not a clear pathway which links the abuse event to the short-term effects to specific long-term disorders. However, as figure 1 suggests, it is possible that the short-term effects may lead to biological, interpersonal or psychological vulnerabilities which may leave an individual more likely to develop adult psychopathology. For this reason, in the following sections the literature is examined to broadly follow this hypothesis. The short-term effects of CSA will be reviewed, followed by the factors suggested to moderate and mediate the effects of the abuse, finishing by examining the evidence linking adult psychopathology with CSA.

In a review of the short-term effects of CSA, Beitchman et al. (1991) found that with the exception of sexualised behaviour, the majority of short-term effects noted in the literature are symptoms that characterise child clinical samples in general, for example behavioural problems. Among adolescents, commonly reported short-term effects of CSA include sexual dissatisfaction, promiscuity, homosexuality, and an increased risk for revictimisation. Depression and suicidal ideation or behaviour also appear to be more common among participants with CSA compared with both normal and psychiatric non-abused controls. However, Beitchman et al. (1991) comment that the literature reviewed is often vague in separating the unique effects of the sexual abuse from effects that may be due to pre-existing psychopathology in the child, family dysfunction, or to the stress associated with disclosure.

Mediating and moderating factors

There is a wide variation in response to CSA, with some individuals suffering protracted impairment and others experiencing less severe long-term effects. Research has pointed to a wide range of factors thought to moderate and mediate individuals' response to CSA. Empirical evidence suggests a complex interaction between abuse-related factors, interactions with others (e.g. responses to disclosure, attachment) and individual factors (e.g. attributions, emotion-focused coping) as moderators and mediators of outcome.

Folkman & Lazarus (1988) define a mediator as being generated in the encounter, and changing the relationship between the antecedent and the outcome, the classic example being that of a coping response. They define moderators as factors present

before the event which may influence the outcome of an event but which are not influenced by the event itself, for example gender or socioeconomic variables.

Moderating factors

The evidence suggests a number of factors that moderate individuals' response to CSA. Characteristics of the abuse itself have been investigated, for example greater force, higher levels of sexual activity, and paternal incest are associated with poorer long-term outcome (Browne & Finkelhor, 1986). Researchers have found that strategies of coping can influence long-term adjustment (Bal, Van Oost, De Bourdeaudhuij and Crombez, 2003; Johnson & Kenkel, 1991). It has also been found that there are more optimistic outcomes for CSA survivors with positive family environments and high levels of support than CSA survivors who lack these resources (Spaccarelli & Kim, 1995).

Mediating factors

A number of authors have theorised about the role of coping in mediating the response to CSA (Bal et al., 2003; Merrill, Thomsen, Sinclair, Gold and Milner, 2001). Folkman & Lazarus (1988) distinguished two main coping-strategies: problem-focused and emotion-focused coping. They define problem-focused strategies as an attempt to manage or alter the stressful situation, for example seeking information and advice. In contrast, they suggest that emotion-focused strategies aim to regulate the emotional responses to the situation by changing the way the person attends to, or interprets what has happened, for example avoidance of thinking about the problem by using fantasy or wishful thinking. Bal et al. (2003) investigated the mediating role of coping processes in adolescents, and found that

avoidant coping mediated the relationship between CSA and psychological distress. It was found that avoidant coping was related to outcomes involving emotional distress, active coping related to symptoms of anger, and distraction related to views of interpersonal relationships. It should be noted that this study did not include any other cognitive factors such as sense of control, attributions, or understanding of the abuse. It is of course possible that coping strategies used immediately following the trauma will differ from those used later on. Avoidant coping may be adaptive during or immediately following a trauma, but become a mediator of distress if it continues to be relied on over time.

However, some studies have not found a role for mediation by coping, and have suggested the primary importance of other moderating factors such as prior attachment experience (Shapiro & Levendosky, 1999). In their study of 80 female adolescents, Shapiro and Levendosky (1999) concluded that the variance in psychological distress following CSA was primarily due to the role of attachment, rather than coping. They propose that a secure attachment style may help the survivor to cope with the trauma or provide a type of resilience not present in survivors with insecure attachment styles. It is also possible that attachment experiences may also affect other psychological and interpersonal processes, such as coping. Although there are strengths in studying an adolescent population, in which childhood abuse experiences are more recent, it could be questioned whether it is too early to assess the full extent of individuals' responses to the abuse.

There is some empirical support for Barker-collo and Read's (2003) account in that negative outcomes are associated with close proximity of the perpetrator,

involvement of authorities, engagement of crisis support, and the presence of anxious and/or avoidant attachments. In terms of individual characteristics, self-blame attributions and use of emotion-focused coping strategies are associated with poorer outcomes.

Coffey and colleagues found some evidence that current perceptions of stigma and self-blame mediated the relationship between CSA and adult adjustment as measured by the Brief Symptom Inventory (Coffey, Leitenberg, Henning, Turner and Bennett, 1996). They suggest that feelings of shame and self-blame may impact on adjustment by affecting the survivor's core beliefs or schemas. Young (1999) defined early maladaptive schemas as: "broad, pervasive themes regarding oneself and one's relationship with others, developed during childhood and elaborated throughout one's lifetime, and dysfunctional to a significant degree." It seems highly probable that core beliefs play an important role in influencing the extent to which a person experiences long-term maladjustment following childhood abuse. Briere's (2002) 'Self-Trauma model' incorporates aspects of trauma theory as well as cognitive, behavioural, and self-psychology theory. It incorporates newer ideas in the areas of suppressed or "deep" cognitive activation, schemas, and the effects of early attachment experiences on thoughts, feelings, and memories. Briere (2002) emphasises the role of implicit memories and processes as well as explicit ones. As yet, there is little empirical evidence and more research is needed into the role of core beliefs or schemas.

Adult psychopathology

A history of CSA is consistently associated with a number of interpersonal and psychological difficulties in adulthood (e.g. Beitchman et al., 1992; Briere & Runtz, 1993; Browne & Finkelhor, 1986; Spataro et al., 2004). In their review, Briere and Runtz (1993) found that CSA had relatively direct and sustained impacts on psychological and interpersonal functioning (e.g., posttraumatic stress disorder (PTSD), dissociation, depression, suicidality, impaired self-reference), as well as motivating the development of behaviours that may be adaptive in the short-term but become damaging in the long-term (e.g. substance abuse, eating disorders, self-harm). In addition, Beitchman et al. (1992) found that women with a history of CSA show greater evidence of sexual disturbance or dysfunction, homosexual experiences in adolescence or adulthood, and are more likely than non-abused women to be revictimised. They also found an association between anxiety, fear, and suicidal ideas and behaviour and a history of CSA but they noted that force or threat of force may also have to be present. Beitchman et al. (1992) also found that more frequent abuse, over a longer duration, involving penetration, force or violence, and abusive experiences involving a father or stepfather seemed to be the most harmful in terms of long-lasting effects. They acknowledged, however, that most of the studies reviewed showed some biases in the way the samples were obtained which limits their generalisability. Patients who have been sexually abused as children are more likely to be diagnosed as having a personality disorder (especially of the borderline type) (Briere and Zaidi, 1989). Among a sample of female psychiatric patients, a higher proportion of the incest survivors had affective symptoms, substance abuse, suspected organicity, and major mental health problems, and they spent more time in seclusion than other patients (Beck and van der Kolk, 1987).

Research into the long-term effects of CSA on men has been scarce until recent years. Fromuth and Burkhart (1989) in their study of a sample of 582 college men in the US, found an association between CSA and poor psychological adjustment as measured by the SCL-90 and the Beck Depression Inventory. Research among male clinical populations has found associations between CSA and substance abuse (Moncrieff, Drummond, Candy, Checinski, & Farmer, 1996) and poorer psychological adjustment in general (Swett et al., 1990). Swett et al. (1990) suggest that male patients may have more difficulty in discussing sexual abuse, perhaps because abuse might be more dystonic with sex role expectations for men.

Overall, there is evidence that the relationship between child abuse and psychiatric sequelae in adulthood remains after controlling for potentially mediating variables such as socio-economic status, marital violence, parental substance abuse and psychiatric history, and other childhood traumas (Kendler, Bulik, Silberg and Hettema, 2000). However, there are a small number of studies (e.g. Fromuth, 1986; Harter, Alexander and Neimeyer, 1988) which have found that some of the differences in psychological adjustment between CSA participants and non-abused participants are no longer significant once family environment has been taken into account. Fromuth's (1986) study, using 383 female college students, found that many of the relationships between a history of CSA and measures of later psychological and sexual adjustment were no longer significant when parental supportiveness was controlled. Harter et al. (1988) found evidence suggesting that family characteristics and increased perceptions of social isolation were more predictive of social maladjustment than abuse per se. However, abuse by a paternal

figure was related to poorer social adjustment even after significant family and social-cognitive variables were controlled. In a highly controversial meta-analysis, Rind, Tromovitch and Bauserman (1998), reviewed 59 studies based on college samples. They found that students with CSA were, on average, slightly less well adjusted than controls. However, Rind et al. (1998) concluded that this poorer adjustment could not be attributed to CSA because family environment explained considerably more of the variance in adjustment than CSA. They noted that self-reported reactions to, and effects from CSA indicated that negative effects were neither pervasive nor typically intense, and that men reacted much less negatively than women. Numerous researchers (e.g. Dallam, Gleaves, Cepeda-Benito, Silberg, Kraemer & Spiegel, 2001; Ondersma, Chaffin, Berliner, Cordon & Goodman, 2001) have offered criticisms of this research including its use of 'healthy' samples and its inclusive definitions of sexual abuse.

The association between child abuse and psychotic disorders

Child abuse has been consistently associated with a number of adverse psychological outcomes in adulthood, including psychotic disorders. Among the 'recent advances in understanding mental illness and psychotic experiences' identified by the British Psychological Society (Kinderman et al., 2000) is the finding that many people who have psychotic experiences have experienced abuse at some point in their history. A growing body of research demonstrates this finding in relation to psychosis, often with a focus on schizophrenia, and highlights child abuse in particular.

There is considerable research reporting that child abuse or neglect is related to psychotic symptoms and diagnoses of schizophrenia (Bryer et al., 1987; Friedman &

Harrison, 1984; Lundberg-Love, Marmion, Ford, Geffner & Peacock, 1992; Ross & Joshi, 1992; Ross, Anderson & Clark, 1994; Swett et al., 1990). Recently, Janssen and colleagues (2004) investigated the relationship between child abuse and psychotic symptoms in a large general population sample of 4045 participants. They assessed severity of psychotic symptoms and functional impairment according to the Brief Psychiatric Rating Scale (BPRS) items: 'unusual thought content' and/or 'hallucinations'. They demonstrated that people with a history of childhood abuse were more likely to develop psychotic symptomatology over the 3 year course of the study than non-abused individuals. This finding was robust, and remained significant after controlling for potential confounding variables such as co-morbid psychiatric diagnoses and ethnicity. However, as mentioned, this study only focused on positive symptoms of psychosis, the sample included few participants with a history of abuse, and the measurement of reported abuse was not very refined.

Both CSA and CPA are also significantly related to research measures of psychosis. The Psychoticism scale of the Symptom Checklist-90 (SCL-90R) has been found to be more strongly related to child abuse than any of the other clinical scales (Bryer et al., 1987; Ellason & Ross 1997; Swett et al., 1990). The Schizophrenia scale of the Minnesota Multiphasic Personality Inventory (MMPI) has also been found to be significantly elevated in adults who suffered incest (Lundberg-Love et al., 1992). The upshot of this evidence is not to claim that child abuse is causal of psychosis or schizophrenia, but it does support the association between them; and perhaps still further, that a vulnerability to psychosis or psychotic experiences (as indicated by the various self-report measures) may result from earlier abuse.

The association between CSA and psychotic disorders

In a study of the association between child abuse and psychotic disorders in adulthood, Read, Agar, Argyle, and Aderhold (2003) reviewed the case notes of 200 patients at a community mental health centre in New Zealand. It was found that those who had experienced sexual abuse (in childhood or as an adult) were significantly more likely to endorse two or more of the characteristic symptoms of schizophrenia (as defined in DSM-IV). It should be noted, however that this study was limited in its reliance on case notes. Among women at a US psychiatric emergency room, 53% of those who had suffered CSA had 'non-manic psychotic disorders' (e.g. schizophrenia, psychosis not otherwise specified) compared with 25% of those not abused (Briere et al., 1997). CSA is also related, in the general population, to the Unusual Experiences component (including perceptual aberration) of schizotypy (Startup 1999). Contrary to these findings, although Spataro et al. (2004) found an association between CSA and adult mental disorders in general, they found no specific association between CSA and psychotic disorders.

In patients with other diagnoses, a history of child abuse has been found to 'co-occur' with a high frequency of auditory hallucinations and delusions. CSA has an impact on the later symptom profile of patients with bipolar affective disorder, increasing their vulnerability to experiencing hallucinations (Hammersley, Dias, Todd, Bowen-Hones, Reilly and Bentall, 2003). Patients with PTSD also show increased levels of positive psychotic symptoms including hallucinations, delusions, and bizarre behaviour (Butler, Mueser, Sprock and Braff, 1996). Dissociative identity disorder, which is assumed to be a disturbance resulting from severe child abuse may present with a great number of Schneiderian first-rank symptoms,

particular auditory hallucinations (Ross, Norton and Wozney, 1989). Clinicians frequently observe transient psychotic symptoms, such as auditory hallucinations and delusions, in patients with a diagnosis of borderline personality disorder. It could also be argued that the beliefs held in severe obsessive compulsive disorders represent a delusional style of thinking, even if falling short of formal diagnostic criteria. Honig, Romme, Ensink, Escher, Pennings, deVries (1998) compared the content of chronic auditory hallucinations between patients with schizophrenia, patients with a dissociative disorder, and non-patient voice-hearers. They found no significant differences between the hallucinations of the three groups, however, non-patients were less distressed by their experiences. This study presents evidence that the form of hallucinations experienced by both patient and non-patient is similar, irrespective of diagnosis.

In addition to the fact that psychotic symptomatology can be observed in patients with various non-psychotic diagnoses, diagnosis of patients who present with psychotic symptoms is often fraught with disagreement, confusion and ambiguity. For example, Muenzenmaier, Castille, Shelley, Jamison, Battaglia, Opler, Alexander, (2005) point out that PTSD and schizophrenia may express themselves in symptoms that are difficult to discriminate. Distinguishing symptoms of PTSD are re-experiencing the event, hyperarousal, and avoidance, particularly of trauma-related stimuli. Flat affect may be part of the deficit syndrome of schizophrenia or may be indicative of the emotional numbing often seen in PTSD sufferers as a way of coping with overwhelming anxiety. Bearing this in mind, it is perhaps more fruitful to consider a symptom-focused approach, which does not presuppose a qualitative difference between psychotic symptoms in the context of a psychotic disorder, and

similar symptoms in the context of dissociative identity disorder, bipolar affective disorder, borderline personality disorder or PTSD for example. It could be questioned whether the same mechanisms could account for psychotic symptoms independent of diagnosis. At the same time, it must be acknowledged that the majority of symptom-focused research focuses on samples with a diagnosis of schizophrenia or other psychotic disorders.

Child abuse and specific symptoms of psychosis

A history of child abuse is related to the presence of psychotic symptoms usually considered indicative of schizophrenia. Read and Argyle (1999) found that 77% of psychiatric inpatients who had suffered either CSA or CPA, experienced hallucinations, delusions or thought disorder. However, this study was based on a relatively small sample (N=22) and relied on data from case notes. A community survey of 502 adults in Winnipeg, Canada, found that 46% of those with three or more Schneiderian symptoms of schizophrenia had experienced CPA or CSA, compared to 8% of those with none (Ross and Joshi, 1992). In a sample of 83 patients with a diagnosis of schizophrenia, Ross et al. (Ross, Anderson, & Clark 1994) found that patients who suffered CSA or CPA were significantly more likely than other inpatients to experience voices commenting, paranoid ideation, thought insertion, ideas of reference, visual hallucinations, or reading others' minds. However, Read et al. (2003) did not replicate this finding.

Among 54 adolescent inpatients, those that had suffered CSA were more likely to have hallucinations than those with no history of CSA (Sansonnnet-Hayden et al., 1987). Consistent with this, Read et al. (2003) found that compared with non-abused

patients, CSA survivors were three times more likely to experience hallucinations. In particular, olfactory hallucinations were 11 times more common in CSA patients and 24 times more common in the CSA & CPA group, than in non-abused patients. Read (2003) also found that tactile hallucinations (16%), thought insertion (16%), ideas of reference (20%), evil/Satan content (20%), voices commenting (32%), and paranoid delusions (36%) were found in none of the non-incest cases and in the indicated percentage of the incest cases. Read and Argyle (1999) found that all female incest survivors in their inpatient study experienced hallucinations and that incest survivors were significantly more likely to do so than those subjected to extrafamilial CSA. It is important to consider that this study was based on case notes, and did not include a non-abused control group. Ellenson (1985) identified in a study of 40 women a 'post incest syndrome', including symptoms exclusively associated with a history of childhood incest. Thought content disturbances included recurring nightmares, intrusive obsessions, dissociation, and phobias. Perceptual disturbances included recurring illusions and auditory, visual, and tactile hallucinations. Sansonnet-Hayden et al. (1987) found that in adolescent inpatients, those subjected to CSA were not more likely to have delusions. However, using questionnaire methodology in a sample of 68 female inpatients, Bryer et al. (1987) found more paranoid ideation among patients who had suffered CSA or CPA than those who had not. Beck and van der Kolk (1987) studied 26 female psychiatric patients using a review of case notes and interviews with clinicians, and found that the 12 patients reporting histories of childhood incest were more likely to have sexual delusions than those without a history of incest. Read (2003) found that some of the symptom subtypes, such as paranoid delusions and voices commenting, were

found in incest cases but not in cases of extra-familial sexual abuse. This suggests that incest may represent a qualitatively or quantitatively different subtype of abuse.

Content of symptoms

Some authors have argued that there is a link between the content of abusive experiences and the content of psychotic symptoms. Raune and colleagues (Raune, Kuipers, and Bebbington, 1999. Cited in Brabban & Turkington, 2002) reported some association between themes expressed in delusions and auditory hallucinations and the characteristics of stressful events prior to onset. Read and Argyle (1999) found that the content of 46% of schizophrenic symptoms in adult inpatients who had been abused was related to child abuse, though this is of course a matter of clinical interpretation. For example, they highlighted command hallucinations inciting self-harm often took the voice of the perpetrator. However, this study had a small sample size and obtained data from analysis of case notes. Oruc & Bell (1995) demonstrated the presence of somatic delusions, specifically, delusional parasitosis (the belief that one is infested with parasites such as mites, lice, insects, or bacteria) following rape and sexual assault. However, this finding was based on a single case study, focusing on a victim of the atrocities of the Bosnian conflict and is therefore of questionable generalisability and should be interpreted with caution. Goff et al. (1991) in a study of 61 chronically psychotic outpatients found higher rates of CSA among patients who believed, or had believed in the past, that they were possessed than those with no delusions of possession. More research is needed with larger samples and clearly defined comparison groups to investigate whether different abusive experiences can be clearly related to certain types of delusions.

How might CSA influence the development of psychotic symptoms in adulthood?

Recent models have suggested that early adversities may lead to psychological and biological changes that increase vulnerability to psychosis. According to some cognitive theorists (Garety, Kuipers, Fowler, Freeman, Bebbington, 2001; Bentall, Corcoran, Howard, Blackwood and Kinderman, 2001), early adverse experiences including child abuse create an enduring cognitive vulnerability. Bentall et al. (2001) argue that this vulnerability is characterised by negative beliefs about the self and the world (e.g. about the self as vulnerable to threat, or about others as dangerous), that facilitate external attributions. They have proposed that causal attributions influence self-representations, which in turn influence future attributions: the attribution-self-representation cycle. They argue that biases in this cycle cause negative events to be attributed to external agents and, in this way, contribute to paranoid ideation. Similarly, Birchwood and colleagues have emphasised that childhood experience of social adversity leads to the development of negative core beliefs involving social humiliation and subordination, which in turn may fuel voices and paranoia (Birchwood, Meaden, Trower, Gilbert and Plaistow, 2000).

Some recent research has focused on the mediating role of schemas which constitute tacit knowledge about oneself in relation to other people and the environment and 'develop during childhood, are elaborated throughout an individual's lifetime and are dysfunctional to a significant degree' (Young, 1999a, p9). There is some preliminary suggestion that schemas and delusions may be meaningfully linked (Moorhead and Turkington, 2001; Brabban and Turkington, 2002). Brabban and Turkington (2002) propose that identifying congruence between life events (which may include childhood abuse), schematic vulnerability, and psychotic symptoms is

vital to an accurate formulation and helpful treatment. They suggest that having such a formulation should provide information about why the patient has developed delusions of *this* kind, as opposed to the stress-vulnerability model which only explains why a patient may have developed delusions of *any* kind. However, this research is in its early stages and as yet, is based on the clinical interpretation of single case studies.

Briere's (2002) 'Self-Trauma model' views abuse memories and flashbacks as attempts to integrate the trauma, while avoidance and numbing strategies (such as suppression of the memories, dissociation, and substance abuse) are seen as attempts to regulate the affect triggered in this process. Although this model is usually applied to PTSD, borderline personality disorder, and dissociative disorders, it may help to explain the psychological function of psychotic symptoms. For some abused patients, delusions may be attempts to make sense of the frightening, but unrecognised, abuse flashbacks by explaining them, in a distorted way, in relation to the present rather than the past. Experiencing an abuse 'flashback' in the present (i.e. a voice in the here and now) rather than experiencing it in the context of, and with the recall of, the abuse may act as a defence against overwhelming affect.

Read et al., (Read, Perry, Moskowitz, and Connolly, 2001) have suggested that adverse life events or significant losses might be able to mould the neurodevelopmental abnormalities that underlie the sensitivity to stressors, if they occur early enough or are sufficiently severe. In this radical view, abnormal neurodevelopmental processes may originate from traumatic events in childhood. Specifically, when there is a persistent exposure to stressors and there is a chronic

rise in stress-induced glucocorticoid release, there can be permanent changes in the hypothalamic-pituitary-adrenal (HPA) axis (Heim, Ehlert, Hanker and Hellhammer, 1998; Heim, Newport, Heit et al., 2000). Childhood traumatic events can thus cause permanent dysregulation of the HPA axis, which in turn may underlie the dopaminergic abnormalities that are generally thought to be involved in psychosis. Furthermore, participants with schizotypal personality disorder also have elevated cortisol levels, which suggest that the heightened cortisol release may be associated with a vulnerability to schizophrenia rather than being solely a consequence of psychotic symptoms (Walker and Diforio, 1997).

Ellason and Ross (1997) suggest that there may even be a type of schizophrenia, characterized by positive symptoms, which is trauma-induced. Ross et al. (1994) hypothesise that 'there may be at least two pathways to positive symptoms of schizophrenia. One may be primarily endogenously driven and accompanied by predominantly negative symptoms. The other may be primarily driven by childhood psychosocial trauma and accompanied by fewer negative symptoms.' However, there is as yet little evidence for these distinct sub-types and notions of a schizophrenic spectrum of disorders varying in aetiology and severity remain the orthodox view.

The debate about whether child abuse has a causal role in the development of psychosis is ongoing (Morrison, Frame and Larkin, 2003). Researchers who have made this suggestion (Ellason & Ross, 1997; Read, 1997) have drawn upon the high rates of child abuse among the psychotic population (e.g. Goff et al., 1991; Ross & Joshi, 1992) and the precipitating influence of negative life events on psychotic

symptoms (Kingdon and Turkington, 1994; Romme & Escher, 1989). For example, Romme and Escher (1989) found that 70% of voice hearers developed hallucinations following a traumatic event, and suggested that hearing voices may be a strategy of coping. However, although this study provided rich qualitative data, it was not an empirical study with formal measures to help quantify this conclusion. Honig et al. (1998) compared the form and content of auditory hallucination in three samples (patients with a diagnosis of schizophrenia, patients with a dissociative disorder, and non-patient voice-hearers). They also found that, in most patients, the onset of auditory hallucinations was preceded by either a traumatic event or an event that activated the memory of earlier trauma. In addition, the small body of research which shows some congruence between abusive experience and the content of psychotic experiences has been cited as evidence of a causal role for abuse in the development of psychosis (Read & Argyle, 1999). However, an alternative view would be that psychotic symptoms are always related to a person's developmental history and that if a person has a history of abuse, this will be used in their development of explanations for psychotic experiences.

As yet, the research is not equipped to answer such a question. Some of the studies supporting a causal role for child abuse have small samples or are single case studies, whilst the larger studies often have differing definitions and methodologies for assessing trauma in general, and child abuse in particular, and rely frequently on case-note data. Morrison et al. (2003) suggest that the number of studies with reasonable sample sizes and conservative definitions of abuse that have replicated findings suggest that a relationship does exist between trauma and psychosis. More specifically, they propose that child abuse seems to be implicated in the development

of psychosis for some people. However, more research is needed to elucidate exactly how traumatic life events contribute to the development of psychosis.

Clinical Issues in asking about abuse in psychosis

Despite the consistently demonstrated relationship between child abuse and adult psychopathology, research suggests that the majority of abuse and trauma is unidentified by mental health services in routine clinical practice (Young, Read, Barker-collo, et al., 2001). Researchers studying inpatients or users of psychiatric emergency services have found that the proportion of the abuse reported to them which had been identified by clinicians is low: 30% (Wurr & Partridge, 1996) and 6% (Briere & Zaidi, 1989). It seems that the low rate of abuse identified by clinicians may reflect a failure to ask about abuse. Lothian & Read (2002) conducted a survey of 74 members of mental health consumer groups in New Zealand about their first assessment. Of their sample, two-thirds of the participants reported sexual, physical or emotional abuse at some point in their lives, but only 20% were asked about abuse during assessment. Sixty-nine percent of patients believed there was a connection between having been abused and their mental health problems, but relatively few (17%) thought that their clinician saw such a connection. In a study of 30 inpatients who disclosed CPA or CSA to the researchers, none had been asked about abuse before (Rose et al., 1991). In Briere and Zaidi's (1989) study of 100 female patients in a psychiatric emergency room, 50 files were selected at random, while for the other 50, clinicians were requested to directly ask about past abuse. A substantially higher rate of sexual abuse was found for patients who had been directly asked about sexual abuse (70%) than for the random sample (6%). Read and Fraser (1998a) examined patients' first contacts

with mental health services, and found that even when the admission form included a section specifically for abuse history, only one in five patients were asked the abuse questions. This is of particular significance when considered with the fact that of those from whom an abuse history was taken on admission, 82% disclosed some form of abuse. Of those not asked about abuse on admission only 8% disclosed any form of abuse at any point during their hospitalisation. It seems essential that clinicians know whether patients have been abused, so that they can develop accurate formulations and effective treatment plans. Given that a history of CSA is a stronger predictor of current suicidality than a current diagnosis of depression (Read et al., 2001a), it also seems vital for clinicians to know about abuse histories in order to conduct thorough suicide risk assessments.

Young et al. (2001) outline various barriers to clinicians' inquiries about, and responses to, disclosures of abuse: fear of vicarious traumatization; concern about embarrassing the patient; time constraints; lack of training and confidence; severity of disturbance and fear of exacerbating disturbance; and clinician's beliefs about the reliability of clients' accounts. In their survey of 220 clinicians in New Zealand, Young et al. (2001) noted that clinicians reported that there seemed to be more pressing issues, they feared disturbing clients or that they feared inducing 'false memories'. A lower rate of enquiry was related to the patient having a diagnosis of schizophrenia, or the clinician having biological beliefs about mental illness. Young et al. (2001) found that the self-reported rate of inquiry in this sample was high. However, it is important to note that this study investigated the likelihood of enquiring about abuse and did not ascertain the actual rate of inquiry in practice. It relied on self-report, and therefore incorporates biases such as social desirability.

Research has also found that male clinicians are less likely to ask about abuse and male patients are less likely to be asked about abuse (Lab, Feigenbaum, & De Silva, 2000; Read & Fraser, 1998a). Pruitt and Kappius (1992), in a survey of 105 therapists found that younger therapists, those who had been in practice for a shorter period of time, and whose current caseload included a high percentage of sexually abused women were most likely to enquire about CSA.

It also seems that clinicians are poorly equipped to respond to disclosures. Read and Fraser (1998a) found that there was no documentation that any of the 32 patients in their study who disclosed abuse received any abuse-related support or information during their hospitalisation. Only 9% were referred for post-discharge abuse counselling and none of the alleged crimes, some of which were recent or ongoing, were reported to the authorities. In a US study of an intensive psychiatric care facility, it was found that when clients tried to discuss their abuse backgrounds with clinicians none of the responses were considered appropriate to the clients' need for support based on the impact of their abuse (Rose et al., 1991).

Summary

The research reviewed may offer clues about the role of CSA in psychotic symptoms. Psychotic symptoms may have meaningful roots in childhood experience via the effects on the young individual's developing schematic representation of themselves and others, coping strategies, and/or damage to the psychic structure. These effects may manifest later in adulthood, in symptoms that are traditionally seen as part of psychosis, but are also present in other diagnostic categories, for example hallucinations as part of bipolar affective disorder.

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**Child Sexual Abuse and Delusions:
An Empirical Study**

Part 2

Child Sexual Abuse and Delusions:

An Empirical Study

Abstract

This mixed quantitative and qualitative study explored the links between child sexual abuse (CSA), schemas and delusions in a sample of 16 adult psychiatric patients. Eight participants with a history of CSA (CSA group), and eight with a combination of other forms of abuse excluding CSA (comparison group) completed the Childhood Trauma Questionnaire (CTQ-SF), the Young Schema Questionnaire (YSQ) and were interviewed using selected questions from the Schedules for Clinical Assessment in Neuropsychiatry (SCAN). Three vignettes were created for each participant: (1) Abuse History; (2) Schemas; (3) Delusions. These vignettes were sent to two external panels of experts in clinical formulation of psychosis. The panels were unable to distinguish schema and delusions vignettes between the CSA group and the comparison group at a rate above chance. They were also unable to match the three vignettes for each CSA participant at a rate above chance. The researcher conducted a thematic analysis which extracted five main themes from the delusions of the CSA participants: religion/occult; persecution/surveillance; focus of public attention; badness; and control. There appeared to be some association between religious/occult delusions and the self-sacrifice schema, persecution/surveillance delusions with the mistrust/abuse schema, and delusions of control with the emotional inhibition schema.

Introduction

There is a growing body of research demonstrating a strong relationship between psychotic disorders and childhood abuse (Bryer, Nelson, Miller, & Krol, 1987; Lundberg-Love, Marmion, Ford, Geffner & Peacock, 1992; Swett, Surrey & Cohen, 1990; Janssen, Krabbendam, Bak, Hanssen, Vollebergh, de Graaf, and van Os, 2004), and there is wide speculation as to the nature of such a relationship (Morrison, Frame, and Larkin, 2003). A number of researchers have proposed thematic links between early psychosocial stressors and the content of psychotic symptoms. It has, for instance, been found that patients reporting histories of childhood incest are more likely to have sexual delusions (Beck and van der kolk, 1987). In addition, Raune, Kuipers, and Bebbington (1999) have reported some association between themes expressed in delusions and auditory hallucinations and the characteristics of stressful events prior to onset. Similarly, Read and Argyle (1999) claimed that the content of 54% of schizophrenic symptoms in adult inpatients who had been abused was related to child abuse. Oruc & Bell (1995) reported that somatic delusions such as delusional parasitosis (the belief that one is infested with parasites such as mites, lice, insects, or bacteria) are more common following traumatic life events such as rape and sexual assault. Goff, Brotman, Kindlon, Waites, et al. (1991) found higher rates of CSA among patients with delusions of possession than in those with no delusions of possession. As well as substantiating the relevance of abuse in the histories of these patients, such connections give vital clues that facilitate clinical formulation which is the foundation of psychological therapy. To date, the majority of studies examining the thematic links between abuse and the content of symptoms have relied on single case studies or small samples. They have also established these

thematic links on the basis of *ad hoc* examination of the data, which necessarily leads to subjective interpretation.

How would abuse come to influence delusional content? In this context, cognitive models of the development and maintenance of delusions are increasingly influential (Garety, Kuipers, Fowler, Freeman, Bebbington, 2001; Bentall, Corcoran, Howard, Blackwood and Kinderman, 2001). Bentall et al. (2001) advocate that early adverse experiences such as child abuse create an enduring cognitive vulnerability, characterised by negative beliefs about the self and the world (e.g. about the self as vulnerable to threat, or about others as dangerous), that facilitate external attributions. Bentall et al. (2001) have proposed that causal attributions influence self-representations, which in turn influence future attributions: the attribution-self-representation cycle. They argue that biases in this cycle cause negative events to be attributed to external agents and, in this way, contribute to paranoid ideation. Similarly, Birchwood et al. have emphasised that childhood experience of social adversity leads to the development of negative core beliefs involving social humiliation and subordination, which in turn may fuel voices and paranoia (Birchwood, Meaden, Trower, Gilbert and Plaistow, 2000). Briere's (2002) 'Self-Trauma model' incorporates newer ideas in the areas of suppressed or "deep" cognitive activation, schemas, and the effects of early attachment experiences on thoughts, feelings, and memories. Briere (2002) emphasises the role of implicit memories and processes as well as explicit ones.

Some recent research has focused on the mediating role of schemas which constitute tacit knowledge about oneself in relation to other people and the environment and

'develop during childhood, are elaborated throughout an individual's lifetime and are dysfunctional to a significant degree' (Young, 1999a, p9). There is some preliminary suggestion that schemas and delusions may be meaningfully linked, and that the beliefs which mediate this relationship may form a helpful focus for early therapeutic intervention (Moorhead and Turkington, 2001; Brabban & Turkington, 2002). Furthermore, Brabban and Turkington (2002) propose that identifying congruence between life events (which may include childhood abuse), schematic vulnerability, and psychotic symptoms is vital to the process of accurate formulation. They suggest that having such a formulation should provide information about why the patient has developed delusions of *this* kind, as opposed to the stress-vulnerability model which only explains why a patient may have developed delusions of *any* kind. However, this research is in its early stages and as yet, is based on the subjective clinical interpretation of single case studies. Whilst this largely idiographic research makes a convincing case using relatively idiosyncratic features, it does not address issues of how generalisable and verifiable the claims may be. Clearly nomothetic research is also desirable in this respect, although there is a corresponding danger of losing the finer detail of individual's data. The present research strategy aimed to retain some of the richness of the individual participant's history and experience while allowing more objective comparisons within a small sample. To this end, the study employed vignette methodology.

Vignette methodology has been widely used in research as a practical and systematic way of presenting a manageable amount of information. It has also been employed in checking the reliability of various outcome measures and psychiatric rating scales with varying degrees of success (for example, Shaffer, Gould, Rutter, and Sturge,

1991; Rock and Preston, 2001; Loevdahl and Friis, 1996). It has been argued that reliability is generally better with case-vignettes than with unstructured information from patients, due to a restricted variance of information. However, Loevdahl and Friis (1996) found that General Assessment of Functioning (GAF) scores could not be reliably assigned on the basis of clinical vignettes. Similarly, Shaffer et al. (1991) assessed the inter-rater reliability of a classification scheme of psychosocial stressors using case history vignettes and demonstrated low reliability. Rock and Preston (2001) suggested that written vignettes may not provide a valid basis upon which to measure the inter-rater reliability of Health of the Nation Outcome Scales (HoNOS). Therefore, although vignette methodology has practical advantages in standardising materials and increasing data's manageability, it is not without its limitations as it necessarily involves omission and simplification.

The current study aimed to explore the thematic links between childhood sexual abuse, schemas and delusions in a larger sample than has hitherto been studied. Two methods were employed. Firstly, independent expert raters judged vignette materials, and secondly, thematic analysis was also used. The research questions were as follows:

- (a) Can an external panel distinguish schema vignettes and delusion vignettes which come from individuals with a history of CSA from individuals with a combination of other forms of abuse?
- (b) Can an external panel make meaningful links between the abuse, schema and delusions vignettes of individuals which allow them to match the three vignettes for each individual?

(c) Can the researcher extract characteristic themes from the delusions of individual with a history of CSA?

Method

Participants

The study included 16 participants, including three psychiatric inpatients and thirteen outpatients, of whom nine were male and seven female. They ranged in age from 25 years to 60 years (mean=40 years). Inclusion criteria were: (a) disclosure of moderate or severe childhood physical or sexual abuse before the age of 16, as assessed by the Short form of the Childhood Trauma Questionnaire (Bernstein & Fink, 1998; Bernstein, Stein, Newcomb, Walker, Pogge, Ahluvalia, et al. 2003); (b) a primary DSM-IV diagnosis of a psychotic disorder (APA, 1994), e.g. schizophrenia, schizoaffective disorder, delusional disorder; (c) written informed consent to participate in the research (see Appendix 1 for consent form). Participants were excluded if they had disclosed significant abuse in adulthood. This relatively broad sampling framework was intended to maximise the generalisability of the study. Table 1 summarises the demographic aspects of the sample.

Table 1: *Demographic aspects of the sample*

Age	Gender (M or F)	In- or Out-patient	Abuse Type (S, P, E, EN, PN)
<i>All participants</i>			
Mean = 40 years	9 Male	3 inpatient	All types of abuse
Range = 25 to 60	7 female	13 outpatient	
<i>CSA Participants</i>			
Mean = 39 yrs	2 Male	1 inpatient	S and a combination of other forms of abuse
Range = 28-51	6 Female	7 outpatient	
<i>Comparison Group</i>			
Mean = 41 yrs	7 Male	2 inpatient	No S.
Range = 25-60	1 Female	6 outpatient	A combination of other forms of abuse

Note: Abuse type is indicated using abbreviations: S (sexual abuse), P (physical abuse), E (emotional abuse), EN (emotional neglect), and PN (physical neglect).

Abuse type and severity were ascertained according to the CTQ-SF

Recruitment

Out-patients were recruited either by referral from a member of the patient's Community Mental Health Team (CMHT) or following assessment for psychological treatment at the Psychology Department. Inpatients were primarily recruited via referrals from the ward manager or keyworker. Review of patients' medical notes and discussions with the care team yielded a number of potential participants who had disclosed childhood abuse and who had been diagnosed with a psychotic disorder. The sampling was thus non-random. Potential participants were asked either by the researchers, a member of the care team or the assessing clinical psychologist in the psychology department, to complete the Childhood Trauma Questionnaire (see Appendix 2 for information for participants and Appendix 3 for information for clinicians). To be included in the study, participants were required to score in the moderate or severe range on the physical and/or sexual abuse scales. Eight participants were recruited with moderate/severe sexual abuse (and a combination of other forms of abuse). These are referred to as CSA participants. Eight participants were recruited with no sexual abuse, but a combination of other forms of abuse. These formed the comparison group.

Procedure and Measures

Participants were asked a number of brief background questions (e.g. age, marital status, occupational status) at the start of the interview (see Appendix 4 for interview protocol).

The participants' childhood abuse history was assessed using the Childhood Trauma Questionnaire (Short form) (Bernstein & Fink, 1998). This 28 item questionnaire is an easily administered, retrospective, self-report questionnaire which examines abuse

experiences according to five categories: physical, sexual and emotional abuse, and physical and emotional neglect (see Appendix 5). The Childhood Trauma Questionnaire also distinguishes abuse experience by severity: none, low, moderate and severe. In addition, participants were also asked brief supplementary questions regarding the identity of the abuser, age at onset, duration and frequency of abuse, and in the cases of sexual abuse, whether full sexual intercourse was involved. A number of studies have demonstrated the reliability and validity of the Childhood Trauma Questionnaire across clinical and community samples as well as adolescent and adult samples (Bernstein, Ahluvalia, Pogge and Handelsman, 1997; Paivio and Cramer, 2004; Bernstein, Stein, Newcomb, Walker, Pogge, Ahluvalia, et al. 2003; Scher, Stein, Asmundson, McCreary and Forde, 2001). Recent research has also demonstrated the predictive validity of the short form of the Childhood Trauma Questionnaire in non-clinical samples (e.g. Paivio and McCulloch, 2004).

Participants were also asked to complete the Young Schema Questionnaire (Young, 1999) in order to construct a 'schema profile' (Appendix 6 contains the short and long forms of the Young Schema Questionnaire and schema descriptions). The 205 item long form and 75 item short form assess the extent to which a person holds a number of 'Early Maladaptive Schemas'. Young defines Early Maladaptive Schemas as: "broad, pervasive themes regarding oneself and one's relationship with others, developed during childhood and elaborated throughout one's lifetime, and dysfunctional to a significant degree" (Young, 1999a, p9). The short-form of the questionnaire consists of a subset of items from the long-form and contains the same schemas as the long-form. Participants completed either the long- or short-form of the Young Schema Questionnaire depending on a number of purely practical

considerations such as the participant's ability, levels of concentration and time constraints. As yet, the psychometric properties of the Young Schema Questionnaire have not been widely researched, however there is evidence that demonstrates the reliability and validity of the tool (Schmidt, Joiner, Young and Telch, 1995; Lee, Taylor and Dunn, 1999).

Finally, a semi-structured interview was conducted, consisting of sub-sections of the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) (World Health Organisation, 1995). The SCAN is a standardised assessment schedule with demonstrated psychometric properties, which has been widely used in research (e.g. Rijnders, van den Berg, Hodiament, Nienhuis, Furer, Mulder, et al. 2000). Moreover, although the instrument is conventionally used with training, it has been demonstrated that experienced interviewers can also apply the SCAN reliably (Rijnders et al. 2000). The purpose of this research called for a method of systematically gathering information about an individual's delusions, and items were therefore selected from the SCAN that were relevant to psychotic symptoms in general and delusions in particular (see Appendix 4 for interview protocol). The participants' responses to items from the SCAN were used to construct an account of the participants' delusional beliefs which was written by the researcher immediately after the interview and checked and signed by the participant. With participants' consent, this interview was audiotaped.

Creation of Vignettes

Three anonymised vignettes were created for each participant using the data from the Childhood Trauma Questionnaire, Young Schema Questionnaire and SCAN. The

vignettes were entitled 'Abuse History' 'Schemas' and 'Delusions' (see Appendix 7 for sample vignettes).

The Abuse History vignette included background information, severity of the different forms of abuse experienced (according to the Childhood Trauma Questionnaire) and a description of the abuse. The Schema vignette listed the schemas which a participant highly endorsed. Despite the use of the Young Schema Questionnaire as a clinical tool, there are no standardised scoring criteria leading to cut-offs as yet. For the purposes of this research, a participant was considered to highly endorse a schema when scoring 75% or above. This cut-off resulted in 0 to 7 schemas contributing to each profile (mean = 3), suggesting reasonable selectivity as a criterion. The Delusions vignette was largely based upon the written account signed by the participant, however, for particularly complex interviews it was necessary to review the tape-recorded interview and notes. Most participants reported a number of different beliefs, which were recorded in the vignette in order of importance for the participant. In order to check the reliability of the construction of the Delusions vignette, one researcher constructed a vignette from the tape recording and notes made by the other researcher. Very good agreement was found between the vignettes of the two researchers.

The vignettes were assigned random codes and sent to two different panels of experts who were selected on the basis of their expertise in psychosis research and clinical practice (see Appendix 8 for further details of the panels). They were asked to complete two tasks: (1a) to separate the Schema vignettes according to those thought to arise from sexual abuse and those thought to arise from a combination of other forms

of abuse (i.e. physical, emotional or neglect); (1b) to separate the Delusions vignettes according to those thought to arise from sexual abuse and those thought to arise from a combination of other forms of abuse (i.e. physical, emotional or neglect); (2) Given the three vignettes for 8 participants who have experienced sexual abuse, to place the Abuse History, Schemas and Delusions vignettes together for each individual. In addition, the panels were requested to provide details of the rationale underlying their responses; the hints and clues in the vignettes that informed their decisions (see Appendix 8 for instructions to panels).

In addition, the researcher conducted a thematic analysis of the delusions vignettes of the eight CSA participants, with the aim of describing the themes or patterns that characterised participants' delusions. Barker, Pistrang and Elliott (2002) outline three key stages in this process: identifying meaning; categorising; and integrating. Identifying meaning entailed going through the vignettes and trying to identify the ideas that were expressed. The next stage of categorising, involved grouping together the important concepts into key themes. The themes were rooted very much in the data and there was a low level of inference. The researcher's own words were used to best fit the data. The final stage of integration represented an attempt to make connections between the themes. To check the credibility of the thematic analysis, an additional analysis of four of the eight delusion vignettes was conducted by another researcher using just the themes described. Very good agreement was found, with the researchers agreeing on 96% of themes.

Ethical Issues

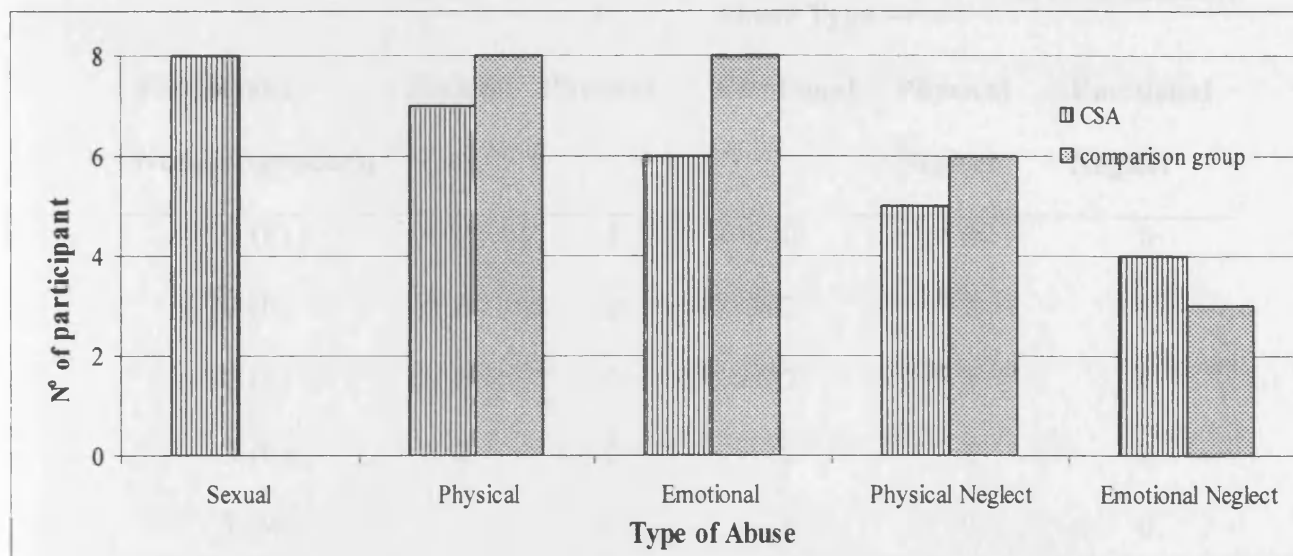
This study was reviewed and approved by Barnet, Enfield and Haringey LREC

(Local Research Ethics Committee. See Appendix 9 for official letter giving ethics approval). The primary ethical issue was the potential for participants to become distressed by recalling and discussing their experiences of abuse. However, research suggests that the majority of people find it helpful to be given the opportunity to discuss their experiences of abuse in a contained manner (Young, Read, Barker-collo & Harrison, 2001). In addition, it was hoped that the use of structured questionnaires and interviews, as well as regular communication with members of the participants' care team would contain any distress. The researchers met with each participant to discuss the research before the interview and answer any questions. The participants were reassured that they could stop the interview at any time and furthermore, a consultation with a clinical psychologist was available if they experienced distress following the interview.

Results

Figure 2 outlines the different abuse types found within the 16 participants of the CSA and the comparison group, and illustrates the heterogeneity of the sample with respect to abuse type. As a consequence of the selection criteria, sexual abuse is the only abuse type which is present in all the CSA participants and none of the comparison group. The other abuse types – physical, emotional, physical neglect and emotional neglect - are found in both groups to varying degrees. Table 2 details the different types and severity of abuse found within the eight participants of the CSA group. It can be seen that although sexual abuse was present for all participants, the severity varied. Similarly, for the other abuse types found in the

Figure 2: Abuse types within the CSA and comparison group



Note: an abuse type was said to be present if the participant scored within the moderate or severe range of the CTQ-SF.

Table 2: Abuse types and severity within the CSA group

Participant Number(gender)↓	Abuse Type →				
	Sexual	Physical	Emotional	Physical Neglect	Emotional Neglect
1 (F)	1	1	0	0	0
2 (F)	2	2	2	2	2
3 (F)	2	0	2	2	2
4 (F)	2	2	2	2	2
5 (M)	2	2	0	0	0
6 (F)	2	2	2	2	1
7 (M)	1	2	2	1	1
8 (F)	2	1	2	0	0

Note: 2 indicates a severe level of abuse, 1 a moderate level of abuse, and 0 indicates that the abuse type was absent

CSA group, the severity varied from being absent, to being present to a moderate level, to severe levels of abuse. There was a gender difference between the two groups, with the CSA group predominantly female (six females out of eight) and the comparison group predominantly male (one female out of eight).

Table 3 details the number of schemas highly endorsed by each group, and shows that there are several schemas held by participants in one group but not by another. Defectiveness/Shame and Dependence Incompetence schemas were held by members of the comparison group but no participants in the CSA group. In contrast, Enmeshment/undeveloped self, Insufficient self-control/self-discipline, and Emotional inhibition were held by members of the CSA group but no participants in the comparison group.

Across the two groups, the mean number of schemas highly endorsed was 3.2 (with participants ranging from zero to seven). The mean number of schemas highly endorsed was higher in the CSA group (4), than the comparison group (2.4). Table 4 indicates the frequency of each schema among the 8 CSA participants. There were a number of schemas which no participant highly endorsed: Abandonment/instability; Defectiveness/shame; Dependence/incompetence; Failure; and Entitlement/grandiosity. The highest proportion of participants (five) highly endorsed the Mistrust/Abuse schema. Half the participants (four) highly endorsed the Emotional deprivation, Social Isolation/alienation and Vulnerability/Harm schemas. Fewer participants (three) scored highly on the schemas relating to Insufficient self-control/self-discipline, Self-sacrifice, Emotional inhibition, and Unrelenting standards. Only one participant highly endorsed the Enmeshment/undeveloped self and Subjugation schemas.

Table 3: *Number of schemas highly endorsed within the CSA and comparison group*

Schema	Abbreviation	Number of participants who highly endorsed schema	
		CSA	Comparison
AB	Abandonment/instability	0	0
MA	Mistrust/abuse	5	3
ED	Emotional deprivation	4	4
DS	Defectiveness/shame	0	1
SI	Social Isolation/alienation	4	3
DI	Dependence/incompetence	0	2
VH	Vulnerability to harm/illness	4	1
EM	Enmeshment/undeveloped self	1	0
FA	Failure	0	0
ET	Entitlement/grandiosity	0	0
IS	Insufficient self-control/self- discipline	3	0
SB	Subjugation	2	3
SS	Self-sacrifice	3	1
EI	Emotional inhibition	3	0
US	Unrelenting standards/hypercriticalness	3	1

Note: The schemas have been referred to by the abbreviations used by Young (1999).

Table 4: *Frequency of schemas within the CSA participants*

Participant N° (gender) ↓	Schema →														
	AB	MA	ED	DS	SI	DI	VH	EM	FA	ET	IS	SB	SS	EI	US
1 (F)		1											1		
2 (F)			1										1		
3 (F)		1	1		1		1					1			1
4 (F)		1			1		1				1				
5 (M)		1	1								1			1	
6 (F)		1	1		1		1							1	1
7 (M)					1		1	1				1	1	1	1
8 (F)											1				
Total	0	5	4	0	4	0	4	1	0	0	3	1	3	3	3

Note: 1 indicates that a schema was present. 0 indicates that the schema was absent.

There seemed to be a trend towards a gender difference, with two out of the three people who highly endorsed the Emotional inhibition schema being the two male participants. It is also possible that the difference between the groups in the number of schemas highly endorsed may also reflect a gender difference.

Vignette Task

Table 5 outlines the panels' responses to the tasks. In task one, Panel one was able to correctly discriminate 10 out of 16 schemas according to those from CSA participants and those from the comparison group. Panel two correctly discriminated eight out of 16 schemas. Panel one correctly distinguished eight out of 16 delusions between those from CSA participants and those from the comparison group, whilst Panel two correctly distinguished nine out of 16. In task two, both Panel one and two were able to match the abuse history vignette to delusion vignette in two out of eight cases. Panel one matched the abuse history vignette to the schema vignette in two out of eight cases and panel two, in one out of eight cases. Neither panel were able to match the schema vignette with the delusion vignette in any cases. Neither panel could match all three vignettes: abuse history, schema or delusions vignette, for any participant. Whilst it is possible to subject the results to formal reliability analysis (Kappa coefficients), it can be seen that the results fall very close to chance levels (10 out of 16, and eight out of 16 in task one, and two out of eight in task two).

Table 5: *Panels' responses to the vignette tasks*

		N° correctly matched	
		Panel 1	Panel 2
TASK 1	S matched to abuse type	10 (out of 16)	8 (out of 16)
	D matched to abuse type	8 (out of 16)	9 (9 out of 16)
TASK 2	A matched to S	2 (out of 8)	1 (out of 8)
	A matched to D	2 (out of 8)	2 (out of 8)
	D matched to S	0 (out of 8)	0 (out of 8)
	A, S, and D all matched	0 (out of 8)	0 (out of 8)

Note: S=schema vignettes, D=delusions vignettes, A=abuse history vignettes

Thematic analysis

The delusions vignettes of the eight CSA participants were examined and five main themes were extracted: religion/occult; persecution/surveillance; focus of public attention; badness; and control. A further category of anomalous experiences was also found based on the wider results of the SCAN interviews.

The theme of religion/occult incorporated delusions relating to black magic, spirits, God and the devil. In most cases the beliefs were malignly personal and experienced negatively. Some examples from the vignettes include:

“H has felt that the spirit of Osama Bin Laden is inside him”

“J describes a ‘creepy feeling’...feeling ‘spooked’...J believes the feeling may be someone making contact from the spirit world”

“B believed that there was a man in the local neighbourhood who was practising black magic on B”.

The persecution/surveillance theme included delusions relating to feeling at risk of harm or attack, and being watched or monitored seemingly with malign intent. Some examples from the vignettes include:

“C felt that people were trying to harm C...C was also frequently concerned that the managers of the accommodation were spying on C through cameras in the light fittings in the building”.

“D has a strong sense that there are people planning to attack. D hears a thought echoing repeatedly, ‘you’ll be attacked, attacked, attacked....”

The Focus of public attention theme referred to delusional beliefs about everyday events or undue attention being directed at the individual:

“Sometimes D’s thoughts are broadcast on TV, for example, a message predicting the end of the world, and D feels that it is a message especially for him/her”

“It...feels like the public are tracking H’s path, by phoning each other to say ‘H’s on their way’”.

The theme of badness incorporated delusions about being dirty, rotten or bad in some way in the eyes of others. In all cases, participants reported a general sense, and were unable to elaborate what exactly it was that was bad.

“As H passes, (people) turn their backs on H because they see something bad in H”

“People see F as their enemy and that...(they)...can’t stand the sight of F”

“D believed that the neighbours thought D was dirty”

Finally, the theme of control referred to delusions about being under the control of ‘people in authority’ or being programmed. No participants were able to identify the specific persons/entity seeking to control them.

“C felt there were people who wished to take control over C and make C like a robot under their control”

“B felt that people in authority are seeking to control him/her”

“P reported feeling unnatural, as if programmed to act in a particular way”

For all eight participants, anomalous experiences were present including auditory, visual or olfactory hallucinations, feelings of unreality, or strange sensations of touch. In some cases the participant had developed a delusional explanation of the experience, for example, a participant who had felt ‘shivers down her spine’ explained this as someone trying to contact her from the spirit world. In other cases, the anomalous experience had not been interpreted further, for instance, another participant felt that she smelled of mothballs even when she was quite clean, but had not sought to explain this experience. For the purposes of this research, anomalous

experiences were not categorized any further because although they are highly related to delusions, they are somewhat distinct from them in classical nosology.

Table 6 outlines the frequency of each theme within the eight CSA participants' delusions vignettes. A high proportion of the participants (six out of eight) had developed delusions of persecution/surveillance. For a similarly high proportion (five out of eight), delusions of religion/occult were present. Fewer than half the participants (three out of eight) experienced delusions relating to badness and being controlled. Of the three participants reporting delusions of control, two were the men in the group, which may suggest a gender difference in types of delusion. Delusions relating to being the focus of public attention were only present for two participants. Within the category of anomalous experiences, three participants experienced delusions of smell that had not been interpreted further.

Table 7 illustrates the correspondence between delusional themes and schemas. It appeared that delusions of persecution/surveillance were most associated with the Mistrust/abuse schema, in that for four out of eight participants, this schema and delusional theme co-occurred (although these were the most common delusion and schema among the participants). Other delusional themes were less strongly associated with certain schemas: delusions of religion/occult with the Self-sacrifice schema; and delusions of control with the Emotional inhibition schema.

Table 6: *Frequency of delusional themes in the CSA participants*

Participant N^o (gender)	Religion/ Occult	Persecut./ Surv.	Focus of attention	Badness	Control	Anomalous experiences
1 (F)	1					1
2 (F)		1	1	1	1	1
3 (F)		1	1	1		1
4 (F)		1		1	1	1
5 (M)	1	1				1
6 (F)	1					1
7 (M)	1	1			1	1
8 (F)	1	1				1
Total	5	6	2	3	3	8

Note: 1 indicates that a theme was present. No figure is recorded if a theme was absent

Table 7: Correspondence between delusional themes and schemas

Schema ↓	Religion/Occult	Persecut./ Surv.	Focus of attention	Badness	Control
AB					
MA	2	4	1	2	2
ED	1	3	1	2	2
DS					
SI	2	3	1	2	2
DI					
VH	2	3	1	2	2
EM	1	1			1
FA					
ET					
IS	2	2	1	1	1
SB	1	2	1	1	1
SS	3	2			1
EI	1	3		1	3
US	1	2		1	2

Note: For each participant, the highly endorsed schemas and delusional themes were recorded. The numbers refer to the number of participants for which the delusional theme and schema co-occurred. For example, 4 participants had a delusion of persecution/surveillance and endorsed the Mistrust/abuse schema. No figure is recorded if the number was zero.

Discussion

The external panels were unable to distinguish schema vignettes and delusions vignettes between the CSA participants and the comparison group at a rate above chance. They were also unable to match the three vignettes for each CSA participant at a rate above chance. The researcher was able to extract five themes from the delusions of the CSA participants: religion/occult; persecution/surveillance; focus of public attention; badness; and control. A further category of anomalous experiences was also found. Using this methodology, the current study did not find support for the assertion made by some researchers that life events, core beliefs and the content of psychotic symptoms can be meaningfully linked (e.g. Brabban and Turkington, 2002).

As might be expected of individuals with a history of abuse, the highest proportion of participants highly endorsed the Mistrust/abuse schema, with a sizable number also endorsing the Emotional deprivation schemas. Fowler, Garety, and Kuipers (1995) have identified five main schematic themes among people with psychosis: the self as extremely vulnerable to harm (“I’m unsafe”); the self as vulnerable to losing self-control (“I’m dangerous to others”); the self as doomed to social isolation (“I’m alone in the world”); the belief in inner defectiveness (“I am damaged”); and the belief in unrelenting standards (“I must be perfect at all times”). The current study found some support for these schematic themes with half the sample highly endorsing the Social Isolation/alienation, and Vulnerability/Harm schemas. However, the schematic themes of the self as vulnerable to losing self-control, as defective, or as having to maintain unrelenting standards, were not predominant themes in this sample. It seems that on a general level the schemas endorsed were as

one might expect in individuals who have a history of abuse and a diagnosis of a psychotic disorder. However, there did not appear to be a level of specificity which might distinguish the effects of different types of abuse.

There appeared to be some associations between certain schemas and delusional themes although it should be acknowledged that the small numbers can only suggest patterns or trends. Persecution/surveillance delusions co-occurred frequently with the Mistrust/abuse schema. It is plausible that individuals who have been abused in childhood would go on to develop expectations that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage of them, which would then be present in their delusions in later life. Delusions relating to being controlled were most strongly associated with the emotional inhibition schema. Again, it is plausible that abused individuals may have developed beliefs about the importance of inhibiting spontaneous action, feeling, or communication, to avoid disapproval by others, feelings of shame, or losing control of one's impulses. These beliefs about controlling oneself might then be related to delusional themes about the self as being controlled by an external being or person. Religious/occult delusions appeared to be associated with the Self-sacrifice schema. Bentall, Corcoran, Howard, Blackwood and Kinderman, (2001) have suggested that early adverse experiences including child abuse create an enduring cognitive vulnerability, characterised by negative beliefs about the self and the world (e.g. about the self as vulnerable to threat, or about others as dangerous), that facilitate external attributions. They have proposed that causal attributions influence self-representations, which in turn influence future attributions: the attribution-self-representation cycle. They argue that biases in this cycle cause negative events to be attributed to external agents and, in this way,

contribute to paranoid ideation (Bentall et al. 2001). This may help to explain why a high proportion of this sample had delusions relating to being persecuted or watched. It is interesting to note that in this sample, delusions of control referred to being controlled by an external entity, and similarly, delusions of badness referred to the fear that others, external to themselves, could see badness in them. It could also be argued that delusions relating to religion and the occult, represent another sort of external attribution, whereby the event is attributed to a spirit, or religious figure external to the individual.

Notably, none of the CSA participants endorsed the Defectiveness/shame schema, which was one of the themes identified by Fowler et al. (1995), and might also be expected in individuals who have experienced CSA. Bentall and colleagues (e.g. Bentall, Kinderman, & Kaney, 1994) have argued that delusions, particularly paranoid delusions may serve a defensive function. They have proposed that patients make external attributions in an attempt to avoid the activation of their negative beliefs about the self. The findings of the current study could be viewed from this perspective although there is no way of vouchsafing any such process in the current sample. It is possible that delusions of being persecuted, watched or controlled, as well as believing others think them to be bad, may serve to reduce endorsement of some negative self-schemas such as defectiveness/shame. Similarly, one can only speculate that the relatively high proportion of participants reporting the experience of unpleasant smells might reflect a similar process of externalisation. However, Garety and Freeman (1999) have argued that low self-esteem is common in patients with persecutory delusions, an assertion which is incompatible with the notion that they serve a defensive function. The evidence on self-esteem in patients with

persecutory delusions is inconsistent at present and as the current study did not assess self-esteem, it is difficult to make such inferences in this sample.

Limitations of the study

There is, of course, a possibility that meaningful links between abuse history, schemas and delusions did exist in this sample, but for a number of reasons, this methodology did not enable us to find them. Vignette methodology has been widely used in research, however a number of authors have found that it can be unreliable. For example, Loevdahl and Friis (1996) found that GAF scores could not be reliably assigned on the basis of clinical vignettes. It appears that the two vignette tasks of the current study represent a much more complex formulation exercise, and indeed both panels reported that the task was very difficult to complete. Whilst the vignette methodology permitted some objectivity and systematisation, it may have screened out important information, as well as the subtleties of intonation, emphasis and non-verbal cues present in live interviews that are so vital to the task of clinical assessment and formulation.

In addition, the study relied on self-report, which has advantages in giving the participant's own perspective, but can cause problems with validity (e.g. individuals deceiving themselves or the researcher). It is possible that the use of self-report measures meant that this study did not capture the reality of the participants' experience. For example, participants may not have endorsed the defectiveness/shame schema consciously and intentionally, rather than as an unconscious defence. Moreover, it is difficult to make cross-case comparisons due to individual differences in completing questionnaires. For example, some

participants had more of a general tendency to highly endorse items than others, which was of particular relevance to the Young Schema Questionnaire. Another possibility is that thematic links can be made between life events, core beliefs and delusional content, but that these links are of a more general nature. In other words, it may not be possible to make the links between specific types of childhood abuse, core beliefs, and delusions. However, it may be that the methodology of the present study was not sensitive enough to pick up these subtleties.

There were a number of other limitations of the study. Firstly, whilst the in-depth qualitative nature of data collection allowed detailed information to be gathered from each individual, it clearly limited the number of participants. The small number of participants in this study does not permit firm conclusions to be made. Rather, this was an exploratory study which suggested trends and interesting directions for future research with larger numbers.

Secondly this sample was extremely heterogenous in many ways. Participants within each group varied in terms of abuse experience, which reflected the complex reality of abuse; all participants experienced a combination of abuse types. However, this meant that making inferences about different abuse types was very difficult. The question remains of whether CSA is qualitatively different from other types of abuse, or whether the difference is quantitative i.e. CSA is *another*, rather than a *different* abuse experience. The sample was also heterogenous in terms of diagnosis. One of the inclusion criteria was a diagnosis on the schizophrenic spectrum, however in reality many participants had been given multiple diagnoses and the decision to exclude delusions in the context of, for example, bipolar disorder, was in some ways

arbitrary. There were also differences in gender between the groups, with the CSA group predominantly female, and the comparison group predominantly male. This makes it difficult to exclude the possibility that any trends found may reflect a gender difference rather than a trend attributable to abuse type. Participants also differed in their level of insight. Some participants were inpatients and fully immersed in their delusions; others had come to terms with their delusions and viewed them as strange beliefs they had held in the past. It is possible that level of insight or length of psychiatric history may have some influence on delusional content.

Thirdly, the reliability of the abuse disclosures could be questioned, as disclosures were not corroborated. However, Dill, Chu, Grob, and Eisen, (1991) have found abuse disclosures by psychiatric patients are reliable and that patients tend to underreport abuse histories rather than over-report them. In addition, Darves-Bornoz Lemperiere, Degiovanni, & Gaillard, (1995) have found that patients with a diagnosis of schizophrenia are no more likely to make incorrect allegations of sexual abuse than the general population. It is of course possible that some of the comparison group also had a history of CSA but did not disclose it.

Fourthly, the Young Schema Questionnaire may not be a valid and reliable method of assessing schemas in this particular population. Although beyond the scope of this study, it would be interesting to see how the ratings of core beliefs/schemas made by clinicians working therapeutically with patients might compare with the schemas those patients highly endorse on the Young Schema Questionnaire. Neither the Childhood Trauma Questionnaire nor the Young Schema Questionnaire captured

the meaning or subtlety of the experience or belief. As mentioned, this reflects the sacrifice of complexity for the sake of systematic data collection. In addition, although the majority of research supports the psychometric properties of the Childhood Trauma Questionnaire, some research casts doubt on the validity of the five factors. Villano et al. (2004) and Paivio and Cramer (2004) found that the physical neglect factor was not stable, whilst Wright et al. (2001) found the physical abuse factor was unstable.

It is possible that the questions in the SCAN interview may have missed some aspects of a participant's delusions, however most participants agreed with the written version of their delusional beliefs and few, if any, made any amendments. The researchers were not trained in using the SCAN, however it has been demonstrated that experienced interviewers can also apply the SCAN reliably (Rijnders et al. 2000). In addition, for the purposes of this study, the SCAN was not used as a diagnostic instrument.

Fifthly, although the data collection and creation of vignettes were conducted to maximise objectivity, nevertheless, there was an element of subjectivity in creating the delusions vignettes. The researchers, however, tried to reduce this by conducting a credibility check.

Finally, the small sample size clearly limits the generalisability of our results. The themes identified are not claimed to capture the entirety of delusional content in patients who have survived abuse nor should the absence of links, at least by the present methods, be taken as definitive.

Future research

Further studies may focus on larger samples, which would allow comparisons to be made, for example, between CSA participants and participants with other combinations of abuse, or between abused and non-abused participants. Alternatively, future research might study fewer individuals in greater depth, aiming to capture more of the participants' interpretation of experiences and the meaning they attribute to them. Variations of the vignette methodology could be applied, for example, the use of videotaping to retain the verbal and non-verbal cues lost in written vignettes. The anomalous experiences reported by individuals, not interpreted for the purposes of this study, might also warrant further investigation.

In summary, this exploratory study did not find evidence that there are meaningful thematic links between an individual's history of abuse, core beliefs or schemas and content of delusions using this methodology. However, it did discover some themes within the delusions of adults sexually abused as children which appeared to be associated with certain schemas and also uncovered some potential pitfalls in applying vignette methodology to this type of research in this population. This study did not include the number of participants necessary to make comparisons or form firm conclusions; however it suggested some interesting trends and patterns which may form a starting point for future research.

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Child Sexual Abuse and Delusions:

Critical Review

Part 3

Critical Review

In this review, I will reflect on the process of conducting this study, highlighting some of the key decisions and issues that were raised along the way. I will begin by considering issues of design and how the project took its broad shape. Next, I will explore the realities of recruitment and the implications of the sample achieved. I will continue by examining the process of interviewing from my own, and also from the participants' perspectives. Finally, I will consider the analysis of the data and writing up the study and reflect on how my perspective influenced, and was influenced by undertaking this study. Throughout the review, I will refer to the guidelines and principles developed for evaluating qualitative research (Elliott, Fischer, and Rennie, 1999; Yardley, 2000). It is important to acknowledge at this point that this was a joint study. The early stages, recruitment and interviewing were all undertaken with a colleague also doing a D.Clin.Psy major research project. Many of the decisions regarding the design of the project, and also later on, were arrived at together.

Design Issues

The main question at this point, which formed the basis of much deliberation and discussion, was the appropriate methodology to investigate the area of child sexual abuse and delusions. It seemed that there were strong arguments for undertaking a purely qualitative study, which would focus on the meaning and perceived effect of the abuse experience, and understanding the association between individual's abuse experience and delusions. This exploratory approach would focus very much on the

perspective of a small number of participants and would aim to capture the complexity and richness of their experience. On the other hand, there were equally compelling reasons for opting for a quantitative methodology. As yet, research on the links between life events, core beliefs and psychotic symptoms is in its early stages and has been based on researchers making links on an *ad hoc* basis, in small samples or single cases. A more quantitative methodology, using a larger sample, would better equip us to make firmer conclusions as to whether such links can be established in a more objective manner. In the end, we decided on a mixed quantitative-qualitative methodology, which aimed to retain some of the richness of the data obtained for individual participants, whilst allowing for the more objective links to be made. We decided to ask an expert external panel whether *they* could see meaningful links, hoping that this would be more compelling than making the links ourselves. This was a key decision, as the type of methodology would determine the conclusions or suggestions we were able to make. Whilst this mixed methodology had many advantages, it sometimes left me feeling in a middle ground, caught in a uncomfortable conflict between the aim of objectivity and the search for meaning for participants.

As the study used an in-depth method of data collection in a smaller group of participants, we felt it was qualitative in essence. There has been considerable discussion among qualitative researchers regarding how best to evaluate the quality of qualitative research and a number of researchers have developed broad guidelines (Elliott, Fischer, and Rennie, 1999; Yardley, 2000). Elliott et al. (1999) have outlined seven criteria: owning one's own perspective; situating the sample; grounding in examples; providing credibility checks; coherence; accomplishing

general versus specific research tasks; and resonating with readers. Yardley (2000) has developed three broad principles, which are similar in many ways to Elliott et al.'s (1999) guidelines: sensitivity to context; commitment, rigour, transparency and coherence; and impact and importance.

Recruitment and the sample

The sample

During the early stages of the research we formulated our inclusion criteria. Elliott et al. (1999) outline the importance of accomplishing general versus specific tasks, which is similar to Yardley's (2000) principle of rigour. Both authors emphasise using the appropriate sample for the question asked. In our case, the inclusion criteria were relatively broad to enhance the generalisability of the study. However, it was recognised that we could not generalise beyond the population studied. We did not intend, for example, to make inferences about people who have been sexually abused in general, nor about people diagnosed with a psychotic disorder in general.

I had initially hoped for a group of participants with a history of CSA only, and comparison groups with histories of other pure form of abuse, such as CPA only. However, the reality was far more complex, and these pure groups did not exist. In real life, different forms of abuse and deprivation are likely to co-occur. The heterogenous sample that we achieved was reflective of experiences in reality, but meant that making inferences about different abuse types was very difficult. I was left with the question of whether CSA is qualitatively different from other types of abuse, or whether the difference is qualitative i.e. CSA is *another*, rather than a *different* abuse experience.

Recruitment

Yardley (2000) discusses the researcher's sensitivity to context, including consideration of the wider socio-cultural context in which the study takes place as an influence on its conduct and outcome. This issue was particularly pertinent to the recruitment stage of the study. We began to look for potential participants by reading the case notes of the inpatients on the psychiatric wards. It was immediately clear that, with exceptions, there was a general dearth of information on file about patients' childhoods and, more specifically, abuse histories. This is consistent with current research which suggests that despite the consistently demonstrated relationship between child abuse and adult psychopathology, the majority of abuse and trauma is unidentified by mental health services in routine clinical practice (Young, Read, Barker-collo, et al. 2001). Further investigation revealed that there were vast individual differences among clinicians about the content of their assessments and their views about enquiring about abuse. Some clinicians feared 'making the person worse' or felt that childhood experiences weren't relevant enough to the here and now. Others voiced concerns about their ability to respond appropriately to an abuse disclosure. Recruiting participants for our study in this context was extremely hard work. Much time was spent trying to convince clinicians of the importance of enquiring about abuse, let alone encouraging them to refer their patients to our study. The most fruitful avenues of recruitment were a small number of enthusiastic clinicians and referrals from the lead researcher who was carrying out assessments for psychological therapy, which involved enquiry about abuse as a matter of course. It was difficult to maintain the momentum of recruitment, particularly considering the attitude change we were trying to achieve in clinicians' approach to assessment and enquiry about abuse. It was a huge advantage to have to

have the help of the lead researcher, who was a constant presence in the hospital, reminding clinicians about the project and not letting it slip from their minds. There were occasionally inappropriate referrals, including those made without the patient's knowledge. We had to tread a fine line between encouraging clinicians to make more referrals whilst pointing out the inappropriate ones. The challenges we encountered during the recruitment stage necessarily limited the number of participants in our sample. These hours spent during the recruitment stage would hopefully fall under Yardley's (2000) principle of commitment.

I believe that by conducting this study, we were able to raise awareness amongst the clinicians about the high prevalence of abuse in the psychiatric population, and the importance of enquiring about abuse. Indeed some clinicians did report that there had been small shifts in their practice and some were using the Childhood Trauma Questionnaire as a routine part of their assessment.

Data collection

The interview

Within Yardley's (2000) principle of sensitivity to context, she identifies the significance of considering the relationship between participant and researcher. As in much research, this relationship was quite complex in our study. The measures we used, particularly the Young Schema Questionnaire, are normally used in the context of on-going therapeutic work. The nature of the research interview involved asking extremely personal and probing questions without building the rapport that would normally be a prerequisite, and I was sometimes surprised at how readily participants responded. It is probable that these participants' had become accustomed to being

asked probing questions during their experience of the psychiatric system. Participants were offered therapy if they became distressed by the interview, but none took it up. Most participants found it helpful to be able to be given the freedom to tell their story, particularly in the semi-structured SCAN (Schedules for Clinical Assessment in Neuropsychiatry) part of the interview. Although the Childhood Trauma Questionnaire and Young Schema Questionnaire required forced responses, the context of the interview did allow follow-up questions to be asked.

It was occasionally difficult for me to retain my stance as a researcher, and I noticed that it was tempting sometime to lapse into a therapeutic frame of mind. This was particularly relevant during the semi-structured part of the interview where some of the skills needed as a qualitative interview overlapped with those used in therapy, such as empathy and non-judgemental attention. Some participants expressed extremely self-damning ideas which made me want to intervene. For example, one participant bleakly stated that she was to blame for her sexual abuse at the age of six years, as she had not fought back hard enough. These sorts of statements were, unfortunately, quite common during the interview and were very difficult to hear. I was grateful for the support and supervision of my co-researcher and lead-researcher. The potential for confusion of the roles of therapist and researcher was exacerbated further as some participants seemed to find the interview therapeutic. One particular participant expressed how helpful she had found it to see the account of her delusional beliefs written down, and to know that someone had listened and tried to understand her. In addition, some of the information gathered was potentially of therapeutic value, and in one case, at the suggestion of the participant, I passed on his completed Young Schema Questionnaire to his therapist.

I found it very difficult to stick to a time limit during the interview, with one interview lasting more than 4 hours (spread over a number of sessions). I became quicker as I conducted more interviews, but the dilemma remained between efficiency, and giving the participant time to tell their story. Although semi-structured, the interviews varied considerably. Certain areas were more pertinent for some participants than others, some participants were keener to talk than others, and there was inevitably some variation between interviewers. These issues of variation in interviews will have had implications for the level of systematisation we were able to achieve in our data.

We had to take care in interviewing our participants because whilst they had all experienced delusions at some point, they varied considerably in their level of insight at the time of interview. Some participants spoke about delusions as past beliefs, whilst for others, their delusions were still very much active. However, the questions in the SCAN are designed for use with currently psychotic individuals and it was felt that the questions were very sensitively phrased. The reliability of the abuse disclosures of psychotic individuals could also be questioned, however Dill, Chu, Grob, and Eisen, (1991) have found abuse disclosures by psychiatric patients are reliable and that patients tend to under-report abuse histories rather than over-report them. Darves-Bornoz, Lemperiere, Degiovanni, and Gaillard, (1995) found that patients with a diagnosis of schizophrenia were no more likely to make incorrect allegations of sexual abuse than the general population.

Wider context of recruitment

The motives for a participant's agreement to take part in the study are interesting to

consider. As discussed, some participants gained some direct benefit from being able to tell their story and be listened to. During one particularly demoralising interview with a patient (who was not included in the study), it became clear that his primary motive for taking part was the five pound subject fee. It is also possible that an imbalance of power was influential. All the participants were either in- or outpatients within the psychiatric system, a system within which compliance is highly valued. They may have been coerced into participation - led to believe that it was a part of their treatment rather than a choice. We were also part of this system in many ways, although outside of it in others. For example, although the contents of the interview were confidential to the study, if there were issues of risk, the participants care team were informed. It is possible that our position within the system may have affected the information disclosed. For example, participants may have minimised symptoms for fear of returning to hospital; one participant in particular was keen to reassure me that she no longer believed her delusions to be true. Although we tried to explain the project in depth, the question remains: can participants truly give informed consent under these conditions?

Analysis and results

Constructing the vignettes

One of Elliott et al.'s (1999) criteria is the presence of credibility checks. Although we asked participants informally about the process of interview, this might have been carried out more systematically. However, we did check our written account of each participants' delusions and asked for feedback, which would constitute a credibility check and gives some testimonial validity to the study.

When creating the vignettes it was sometimes frustrating to distil the rich information gathered during the interview into the short vignettes. However, it was a systematic method of coping with an otherwise overwhelming amount of data. A credibility check was carried out, whereby my co-researcher listened to the audio-taping of one of my interviews and created her own vignette, which we examined for agreement.

Thematic analysis

My thematic analysis yielded 5 main themes: Religion/Occult; persecution/surveillance; focus of public attention; badness; and control. There was no attempt to categorise these themes further, which may be criticised on the ground of not being coherent, a principle identified by both Yardley (2000) and Elliott (1999). However, this was a basic thematic analysis involving a very low level of inference. Its aim was to generate ideas rather than present a framework of delusional themes. In reporting this part of the analysis, I used examples and quotations from the vignette, as recommended by Elliott et al. (1999) and Yardley (2000). Although the vignettes were not a verbatim record of the participants' words, they were very similar. Hopefully, the reader will judge that it represents accurately the subject matter.

Reflections

We were aware that introducing the schema aspect of the project would immediately slant the project towards a cognitive orientation. Elliott et al. (1999) discuss the importance of owning one's own perspective whereby: "the authors specify their theoretical orientations and personal anticipations, both as known in advance and as

they become apparent during the research” (p 221). My orientation is not necessarily strongly cognitive and I acknowledge that viewing the data from this one orientation could be perceived as limiting. However, we felt that cognitive models of psychosis are increasingly influential and that this decision was therefore appropriate in the light of current research.

My own perspective, which was probably felt more strongly at the outset of the study than at this point, is that meaningful links between life events, core beliefs and delusions do exist. This was not made explicit in the empirical paper and raises the question of whether it is possible to have prior hypotheses and assumptions in mind whilst conducting an exploratory study and remain truly open to the new ideas raised by the data. Elliott et al. (1999) would assert that it is crucial for the researcher to acknowledge his/her own perspective at all stages of the research.

This study has influenced my own clinical practice in that I now ask patients about abuse as a standard part of assessment unless there are very good reasons not to. Although I had previously enquired about a patient’s childhood, I may not have asked about abuse more specifically unless there were hints that it may be an issue. Having considered the literature, and the issues raised during recruitment for this study, I now feel very strongly that patients should be asked about abuse.

I was disappointed that this study did not find evidence that the links exist. It is, of course, possible that the links were present, but that this methodology did not allow us to find them. Yardley (2000) argues that one of the key tests of the validity of a piece of research is whether it tells us anything useful or important or makes any

difference. Despite not finding that these thematic links exist, as judged by an external panel, it was felt that the results of the thematic analysis yielded some interesting ideas for future research. This study also highlights the limitations of vignette methodology in this type of research, which may influence research in the future. In terms of social change and clinical implications, I hope that this research adds to the growing body of evidence which highlights the importance of enquiring about abuse, particularly in the psychiatric population where rates of abuse are typically high and much abuse remains unidentified.

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Appendices

Appendix 1

CONSENT FORM

Title of Project:

Name of Researcher:

Please initial box

1.	I confirm that I have read and understand the information sheet dated.....	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without my medical care or legal rights being affected.	
3.	I am willing to allow access to my medical records but understand that strict confidentiality will be maintained. The purpose of this is to check that the study is being carried out correctly.	
4.	I agree to take part in the above study	

Name of Patient
(block capitals)

Date

Signature

I have explained the nature, demands and foreseeable risks of the above research to the subject.

Name of person taking
consent if different from
researcher
(block capitals)

Date

Signature

Name of Researcher
(block capitals)

Date

Signature

1 for patient;

1 for researcher;

1 to be kept with hospital notes

Appendix 2

Information Sheet for Participants

The relationship between early experience and difficulties in adulthood.

Thank you for agreeing to hear about the work that we are trying to do.

What is the purpose of the study?

I am interested in how people's experiences in childhood affect them later in life. This study aims to look into the possibility of a link between early childhood experience and difficulties developed later in life.

We hope that a better understanding of this potential link will provide information to help develop better treatments for those who use mental health services.

Why have I been chosen?

I would like to interview around 40 people who have experienced difficult childhood environments due to physical or sexual abuse and who have had at some time mental health difficulties.

Who is organising the study?

I am a trainee clinical psychologist at University College London (UCL), working with the psychology department at St Ann's Hospital. This study is supervised by Dr John Rhodes (Clinical Psychologist) at St Ann's, and Dr Oliver Mason (Clinical Psychologist) at UCL.

This study will be finished in June 2007.

What will happen to me if I take part?

If you would like to take part, I will ask you to fill in two questionnaires in your own time. We will then meet (probably at St Ann's Hospital) and I will explain the study, you can ask any questions, and I will ask for your consent to participate. In the meeting, I will ask some questions about your childhood experiences and your current mental health. I will ask you if we can tape-record the interview or if you would prefer us to take notes by hand. If you would like to meet again to discuss your interview, or if you would like to be interviewed in more detail about your experiences we will contact you again to offer you a time.

As part of the project I will need to show some of this information to 3 other psychologists, but before I do I will remove any mention of your name or other information that would allow anyone to guess who you are.

If I ask you to travel to St Ann's at a time when you would not normally be attending an appointment we would like to give you £5 towards your travel expenses.

Are there disadvantages to taking part in the study?

You may be concerned that answering questions about your childhood might bring up painful memories. However, most people find it helpful to have the chance to discuss their childhood experiences, even if these were not always positive. If you

choose you can be offered counselling at the Psychology Department at St Ann's if the interview raises issues which you would like to discuss further.

What are the possible benefits of taking part?

It may be that for you there is no benefit from taking part in the study. However, some people find it helpful to talk about difficult childhood experiences and we hope that the information from this study may help us treat people in the future.

What if something goes wrong?

If you have any concerns or cause to complain about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms are available to you.

Confidentiality - who will know I'm taking part in the study?

Apart from yourself and the researchers, we would ask your permission to tell your care team that you're taking part. Any notes we take or taped interviews will be kept in a secure location only accessed by the researchers. This information will be destroyed at the end of the study.

LREC approval

This study was reviewed by Barnet, Enfield and Haringey LREC (Local Research Ethics Committee).

What will happen to the results of the study?

Arrangements will be made to inform you of the results of the study when it is complete. The finished study may be published but anything that might allow somebody to guess who you are would be taken out. For example we could change your name, age and where you live.

Contact for further information

If you have any questions about the project I would be glad to answer them for you.

Emma Brett (Trainee Clinical Psychologist)
Helen Curr (Trainee Clinical Psychologist).....
John Rhodes (Supervisor and Clinical Psychologist).....

Appendix 3

Information Sheet for Lead Clinicians

The relationship between life history and psychosis

I have been given the name of as a potential participant in a study being undertaken in the Psychology Department at St Ann's. Since is under your care I would like to provide you with some information about the nature of this research.

This study aims to look into the possibility of a link between early childhood experience and the content of individual delusional beliefs developed later in life. We would like to interview around 40 people with a diagnosis of psychosis, who have experienced difficult childhood environments due to physical or sexual abuse.

Barnet, Enfield and Haringey LREC (Local Research Ethics Committee) have approved this study and it will be completed by June 2007.

We hope to find out about three main areas of participants' lives: Firstly their childhood, focusing on the abusive experiences; secondly, their core beliefs or schemas which may have developed as a result of this early experience; finally the content of their delusional beliefs. The information will be gathered using questionnaires and checklists - Childhood Trauma Questionnaire, Young's Schema Questionnaire and the SCAN. In addition, we may interview some participants about how they understand these experiences and we may wish to access their medical file to gain demographic information. Some of this information will be shown to 3 other psychologists, but any identifying markers will be removed to preserve participants' and clinicians' anonymity.

Before taking part, we will meet all participants to provide them with information about the study, answer any questions and to ask for their consent.

Current research suggests that many people will welcome the opportunity to discuss their abusive experiences in childhood, and are unlikely to be distressed by the questions asked. However, participants will be offered psychological therapy at the Psychology Department at St Ann's should the interview raise issues which they feel they would like to discuss further. If you have any concerns about the individual named participating in this project I would be grateful if you would contact myself or my colleagues as soon as possible.

If you have any questions about the project I would be glad to answer them for you.

Emma Brett (Trainee Clinical Psychologist)
Helen Curr (Trainee Clinical Psychologist).....
John Rhodes (Supervisor and Clinical Psychologist).....

Appendix 4

Background Information

Initials

Age:

Marital Status

Years of Education

Occupational status

Diagnosis

Drug / Alcohol Misuse

Any other mental health difficulties

Approximate duration of history of psychosis

Number of Psychiatric Admissions

Current Medication / Treatment

Previous Psychology Involvement

Date Interviewed:

Interviewer:

Place:

Checklist

Consent Form

CTQ

YSQ

Short

Long

SCAN

Written Account

Travel Expenses

Contact information given

Consent to contact for future research

Yes

No

Preferred means of contact

Address

Phone

Introduction

Hi I'm Thanks for coming in today and agreeing to be part of our project.

Did you get the information we sent you about the project?
Did you have a chance to have a look through it?
Do you have any questions about it?

What I am hoping to do today is three things

- Firstly I would like to explain more about why I wanted to speak with you and what the project is about
- Secondly I would like to collect your questionnaires and we can look at them together if you haven't had time to fill them in.
- Next I would like to ask you some questions about your beliefs and experiences recently, and finally we can discuss any questions you have at the end and sort out your travel expenses etc.

Intro & Explanation

I am and I'm a trainee clinical psychologist based at St Ann's Hospital and I am doing this project with another trainee (.....) and John Rhodes who has worked here for a while.

Whilst we have been working here we have been interested in listening to people who have had difficult childhoods to see whether there is a link between the types of experiences that people had in childhood and some of the difficulties that they have then experienced when they are older.

What we mean by difficult childhood is people who were hurt during their childhood, usually in their home, for example *people who have been hit or beaten as a child / people who were sexually abused by which we would mean that you had unwanted sexual experiences when you were younger, possibly from a member of your family.*

Questionnaires

We gave you 2 questionnaires, one which asked about what life was like for you when you were younger and one which is more about what life is like for you now.

Did you get a chance to fill them in –

- Yes – Were there any that you couldn't answer?
 - Were there any that were hard to answer / or that you would like to tell me a bit more about?

- No - Would it be OK if I helped you to look through them now, and you can fill them in with me...

CTQ

This is a questionnaire that asks about people's early life, before they were 16. One of the reasons we hoped to talk to you was becausesaid this was a difficult time for you? Could we go through these questions to clarify that ...?

After questionnaires

Overall summary of childhood experiences? Main difficulties / perpetrators /

YSQ

These questions are a little different because they ask more about how you view things today as an adult. Some of them ask about how you see things, or feel about other people. We hope this will help us have a better idea about what is important to you now that you are older

Tape Recording Interviews

We would like to tape record interviews today, because it is easier for me to be able to listen without making notes. All the tapes and notes will be kept in a locked filing cabinet and no one who is not working with me would be able to listen to them. I would also not write your name on the tape so there shouldn't be any way for anyone to know who it is.

Is it OK to use this recorder?

Questions

Use of data

The tapes and data will be kept whilst we are still finishing the project in a locked cupboard, and will be destroyed when we finish the project. Although we would like to publish the research in the future, anything we wrote about would have all the information about who you are removed, so for example we would change your name, and details like how old you are, where you live so that no-one could make a guess at who we had been talking to.

Info to care team

Your care team will know that we are meeting today, but they will not be allowed to listen to the tapes or see my notes that I take. It is up to you how much or how little you would like to tell them about what we talk about today. But, if I am worried about you I will have to talk to your care team about that.

SCAN

This interview will ask you about lots of different beliefs that you might have. For most people they will have a lot to say about some questions and not so much about others. Sometimes the questions might ask about things that might have been true a while ago, such as when you were younger, or before you came into hospital, but we would like to hear about those times too, so please let me know.

DELUSIONS

Initial screening questions – section 14

14.001 Change in appearance of things

Some people occasionally get a feeling that the appearance of things, or people, or even themselves, has changed. That things look or sound or smell unusual or that time has become distorted. Have you had any feelings like this?

Sec 16

14.002 Delusional and mood perplexity

Have you had the feeling that something odd is going on that you can't explain?

Sec 19

14.003 Interference with thoughts

Can you think quite clearly, or does there seem to be some kind of interference with your thoughts?

Sec 18

14.004 Second sight / Strange presences

What about other unusual experiences that some people have, such as seeing things that others cannot see, having second sight, or being aware of strange presences.

Sec 16

14.005 Hearing Voices

We ask this question of everyone and would like to ask you. Do you ever seem to hear noises or voices when there is nobody about and no ordinary explanation seems possible?

Sec 17

14.006 People too interested in R

Have you had a feeling that people were too interested in you?

Sec 16,

sec 19

14.007 Odd or unpleasant experiences

Have there been any other odd or unpleasant experiences of any kind recently

Sec 17

Sections to be completed –

Section 16

Section 17

Section 18

Section 19 to be completed for all

Section 16 Perceptual disorders other than hallucinations

16.002 For example, do things seem to change in size or shape or colour in a puzzling way?

What is that like?

16.003 Have things looked grey and flat; lacking their usual colour and detail?

Can you describe that?

16.004 Do sounds seem unnaturally clear or loud or objects look vividly coloured or patterns seem particularly detailed and interesting?

16.005 Does your experience of time seem to have changed?

Does it go too fast or too slowly or do you seem to live through events exactly as you have had them before?

16.006 Have you felt recently as though the world was unreal, or only an imitation of reality, like a stage set, with cardboard cut-outs instead of real house or trees?

What was that like?

16.007 Did other people seem to be acting a part, like actors in a play, or like puppets, or even dead?

16.008 Have you felt that you yourself were not a real person, not really part of the living world?

Like being in a dream? "Not really here"?
Like acting in a play with all the lines laid down?

16.009 Do you seem unreal to yourself when you look in a mirror?

16.009 Do you find that you seem to be seeing yourself from outside your body, like a stranger?

16.010 Have you felt that part of your body did not belong to you, looked unfamiliar or the wrong size?

16.011 Does your appearance seem to have changed?

Are your features the same as usual?
Is there really a change that other people can see or is it just a feeling?

16.013 Do you think that part of your body is missing?

Like no head, no brain, no thoughts or no mind

Section 17 Hallucinations

From screening questions

You said you have heard noises or voices when there is nobody about and no ordinary explanation, so I was hoping to hear more about this

17.004 How often do you hear it/them?

*Rarely, every week or so, every day, most of the time?
Has there been a time when you were free for at least a week?*

17.005 What does it (they) say?

*Do you know who the voice belongs to?
Can you give me some examples?
Do they just say a few words or is there a long monologue (or conversation between voices)?
Are they just repeating the same brief sentences over and over?*

17.006 What are the voices like? Are they like a real voice? Can you tell them from my voice, for example?

Is there a special quality to them? What is it like?

17.007 Do you hear them in your head or mind, or in your ears, or as though coming from outside?

Where do they seem to come from?

17.008 Does a voice comment on your thoughts?

Does a voice repeat things you have thought?

Do you hear a voice saying what you are reading, or describing what you are seeing on television as you see it?

How often does it happen?

17.009 Do you hear voices talking to each other or directly to you?

*What do they say to each other?
Do they talk about you between themselves?
Do you ever hear a single voice talking about you?*

What about a voice or voices talking directly to you?

If both, Which kind of voice is more common, the one talking to you or the one talking about you?

17.012 Are there any other characteristics of the voices?

Do you hear them only through other noises? E.g. through aeroplane noises or in the cries of birds

*Do you hear the voice from a part of your body?
Does the voice ever come out of your own mouth?*

17.013 How do you explain the voices? Where do they come from?

Why do you hear them?

*How powerful is the voice?
Content & meaning?*

Visual Hallucination

17.014 Have you had visions or seen things that other people couldn't? What did you see?

Was it flashes or shadows, or formed people or objects

Was it whole scenes or only particular people or objects (with your eyes or in your mind)

Were you half asleep at the time

Has it occurred when you were fully awake

Did you think the visions were real

If a person – did you recognise the person

Did he / she say anything

Could you hold a two way conversation

Do you know anyone else who has had this kind of experience

Detail drug effects, bereavement etc

17.022 Olfactory hallucinations

Have you noticed unusual smells that you cannot account for?

17.003 What is the explanation for the smell

17.024 Do you think that you yourself give off a smell?

Even when you know you are quite clean

Can you describe what that is like?

What is the explanation?

17.025 Do other people think that you give off a smell?

Even when you do not?

*How do they show this – what do you notice?
How do you explain it?*

Do you experience things which other people do not think are there?

17.026 Sexual hallucinations

Do you have any unusual sexual sensations?

Can you describe?

17.027

How do you explain these sensations?

17.028 Do you notice other strange sensations or inexplicable sensations of touch, or temperature, or pain or floating? Or like a crawling sensation under the skin?

What is the explanation for these sensations?

Section 18 – Thought disorder and experience of replacement of will

You said that you had the feeling that something odd was going on that you can't explain, could you tell me a little more about that now?

What is it like
Do you feel puzzled by strange
happenings
Do familiar surroundings seem strange

18.002 Can you think quite clearly or does there seem to be some interference with your thoughts

What is that like
Are you fully in control of your thoughts / actions

18.003 Has it seemed that your thoughts were read by other people?

Can you describe that?

18.004 Do your thoughts seem to sound aloud in your head, almost as though someone standing near you could hear them?

What is that like?

18.005 Does a thought in your mind seem to be repeated over again, like an echo?

Can you describe it for me?

What is it like?

18.006 Do there seem to be thoughts in your mind which are not your own; which seem to come from elsewhere?

How do you think they get in your mind?

18.007 Do your thoughts seem to be somehow public; not private to yourself, so that others can know what you are thinking?

Can you describe that?

18.008 Does there seem to be another stream of thoughts in your mind, not under your control, which might, for example, comment on your thoughts, or on something you are reading or something you have seen or done?

Is that like a voice or is it another kind of thought?

What is that like?

18.009 Do your thoughts sometimes stop suddenly, so that your mind is a complete blank, although you have not yourself wanted to stop thinking

Can you describe that?

*When it stops, do you pick up your thoughts where they left off?
(differentiate from lapse of attention or distraction or anxiety)*

18.010 Are your thoughts actually taken out or sent out of your mind? Do they actually feel like that? So that they are outside your head?

What is that like?

18.011 Is there any other kind of interference with your thoughts?

18.012 Do you feel that your will has been replaced by that of some force or power outside yourself?

Can you describe that?

Is it like being a robot or zombie or puppet, controlled from elsewhere, without a will of your own?

That your intentions have actually been replaced by those of...

18.013 Does....actually speak with your voice? You hear yourself saying things that you don't recognise and you didn't intend?

Does the voice seem to come from your own mouth?

18.014 What about your handwriting - do you seem to write things that you have not intended because it is under the control of?

18.015 Do you actually seem to be a different person altogether, because your actions are outside your control?

*Can you describe that?
For example, were you made to walk, or run by....?*

18.016 Are your emotions/feelings under the control of....so that you do not recognise your emotions/feelings as your own?

18.017 Is there any other kind of control, for example of your impulses? Or of your sensations?

2.041 Have you had fatigue after mental effort, for example, reading or other kind of mental activity?

Is it a distressing effort to concentrate your attention on anything?

Section 19 Delusions

19.001 Have you ever felt that people are unduly interested in you?

Or that things are arranged to have a special meaning?

Or that harm might come to you

*Can you describe that
Can you tell me a bit more about this*

19.002 What about any unusual abilities or talents that some people have, such as second sight, or being aware of strange powers or presences?

*Are you superstitious?
Do you have any special powers that most people lack?
What is that like?
Do you belong to a group of people who also have these experiences /
power?*

19.003 Do people seem to talk about you, check up on you to find out where you are, or follow you about, or record your movements?

*Do they take a special interest or try to photograph you
How do you know this?*

19.004 Do people seem to drop hints meant for you, or say things with double meanings?

19.005 Do you see coded messages or a special significance in the way objects are arranged, or in colours, or in the way things happen?

Can you give me an example?

19.006 Do you find that something that you have previously thought or discussed is quoted on TV or in the newspapers or used to refer to you?

19.007 Are there people about who are not what they seem?
Who are perhaps in disguise?

19.007 Do you see people around who you recognise from earlier in life?

Can you give an example?

19.008 Do you feel that the appearance of people that you know well has changed in ways that suggest that someone might be impersonating them?

19.012 Does anyone seem to be trying to harm you (trying to poison or kill you)?

*Are they particularly singling you out?
How do you experience this?*

19.013 Does there seem to be a conspiracy or plot being what is happening?

How do you recognise it?

19.014 Do people say that you are the jealous type?

*Are you jealous / do you think its true?
What do you do to check up on whether anything is going on?*

19.017 Are you loved by someone who does not publicly acknowledge it?

Who is it?
Was he/she the first to try to begin the affair?
What evidence do you have of these advances?
Do you try to make contact? In what way?

19.018 Do people seem to suggest that you are gay?

*Can you describe them?
How do you explain them?*

2.058 Have you had the experience of being taken over by some other power?

By what? A spirit, deity, person?
Did you lose your sense of personal identity?
Can you describe the experience?
Did you want it to happen?
Was it troublesome for you?

If possession initially welcomed:

Did it continue without your wishing it?
Did it start off at a religious or social occasion?
Have you had that possession experience without being in or going into a
trance?

6.013 Do you tend to blame yourself for something you have done or thought; to feel
guilty or ashamed of yourself?

What is it that you think you have done wrong?
How often do you feel guilty?

6.014 Do you have the feeling that you are being blamed or accused by others
because of some action or lapse or deficiency that you yourself feel was
blameworthy?

How often have you had the feeling that you were being blamed for something really
serious?

Do you believe you have any physical problems which doctors cannot find any cause
for?

Have the symptoms changed over time or have they stayed more or less the same
throughout?

How many doctors have you consulted in the past 2 years?

What investigations were made?

With what results?

Were the doctors reassuring?

Why do you think something is physically wrong?

Have you been told the complaint is a nervous complaint?

Does that seem likely to you?

Have you been taking any medications for that?

Do you have any beliefs about your appearance that other people do not agree with?

Do you believe that there is something wrong with your environment / society / the world that other people do not seem to notice or do not believe is happening?

EXPLANATIONS

Could we go over the explanations for what is happening?

19.021 Do you think there is a religious explanation for what is happening?

19.022 Is anything like hypnotism or telepathy going on?

19.023 Are you influenced or affected by x-rays, radio waves, neutrons, electrons, or machines or anything like that?

Do you think these things are happening for a particular reason?

Are you at fault for what is happening to you / guilty / being punished / worthless?

PERCEPTION

19.009 When this happened, how did you know what it meant?

19.009 Are you quite sure or could you have been mistaken?

19.009 Is there any other possible explanation?

19.009 Have you had any experiences previously that made you think something like this might happen?

19.009 Did this come out of the blue?

Have you had different explanations in the past and changed your mind?

Impact / Coping / Interference with Activities

19.043 You have mentioned(summarise symptoms). Overall, how much interference has there been with your everyday activities because of these problems?

Can you give me some examples?

How do you cope with what is happening to you?

What sort of an impact does this have on the people around you?

Appendix 6

YSQ-L2

Name _____ Date _____

INSTRUCTIONS:

Listed below are statements that a person might use to describe himself or herself. Please read each statement and decide how well it describes you. When you are not sure, base your answer on what you emotionally **feel**, not on what you **think** to be true.

If you desire, reword the statement so that the statement would be even more true of you. Then choose the **highest rating from 1 to 6** that describes you (including your revisions), and write the number in the space before the statement.

RATING SCALE:

- 1 = Completely untrue of me
- 2 = Mostly untrue of me
- 3 = Slightly more true than untrue
- 4 = Moderately true of me
- 5 = Mostly true of me
- 6 = Describes me perfectly

EXAMPLE:

I care about

A. 4 I worry that people ^ will not like me.

1. _____ People have not been there to meet my emotional needs.
2. _____ I haven't gotten love and attention.
3. _____ For the most part, I haven't had someone to depend on for advice and emotional support.
4. _____ Most of the time, I haven't had someone to nurture me, share him/herself with me, or care deeply about everything that happens to me.

5. _____ For much of my life, I haven't had someone who wanted to get close to me and spend a lot of time with me.
6. _____ In general, people have not been there to give me warmth, holding, and affection.
7. _____ For much of my life, I haven't felt that I am special to someone.
8. _____ For the most part, I have not had someone who really listens to me, understands me, or is tuned into my true needs and feelings.
9. _____ I have rarely had a strong person to give me sound advice or direction when I'm not sure what to do.

*ed

10. _____ I worry that the people I love will die soon, even though there is little medical reason to support my concern.
11. _____ I find myself clinging to people I'm close to because I'm afraid they'll leave me.
12. _____ I worry that people I feel close to will leave me or abandon me.
13. _____ I feel that I lack a stable base of emotional support.
14. _____ I don't feel that important relationships will last; I expect them to end.
15. _____ I feel addicted to partners who can't be there for me in a committed way.
16. _____ In the end, I will be alone.
17. _____ When I feel someone I care for pulling away from me, I get desperate.
18. _____ Sometimes I am so worried about people leaving me that I drive them away.
19. _____ I become upset when someone leaves me alone, even for a short period of time.
20. _____ I can't count on people who support me to be there on a regular basis.
21. _____ I can't let myself get really close to other people, because I can't be sure they'll always be there.
22. _____ It seems that the important people in my life are always coming and going.
23. _____ I worry a lot that the people I love will find someone else they prefer and leave me.

24. _____ The people close to me have been very unpredictable; one moment they're available and nice to me; the next, they're angry, upset, self-absorbed, fighting, etc.
25. _____ I need other people so much that I worry about losing them.
26. _____ I feel so defenseless if I don't have people to protect me that I worry a lot about losing them.
27. _____ I can't be myself or express what I really feel, or people will leave me.
*ab
28. _____ I feel that people will take advantage of me.
29. _____ I often feel that I have to protect myself from other people.
30. _____ I feel that I cannot let my guard down in the presence of other people, or else they will intentionally hurt me.
31. _____ If someone acts nicely towards me, I assume that he/she must be after something.
32. _____ It is only a matter of time before someone betrays me.
33. _____ Most people only think about themselves.
34. _____ I have a great deal of difficulty trusting people.
35. _____ I am quite suspicious of other people's motives.
36. _____ Other people are rarely honest; they are usually not what they appear.
37. _____ I'm usually on the lookout for people's ulterior motives.
38. _____ If I think someone is out to hurt me, I try to hurt them first.
39. _____ People usually have to prove themselves to me before I can trust them.
40. _____ I set up "tests" for other people to see if they are telling me the truth and are well-intentioned.
41. _____ I subscribe to the belief: "Control or be controlled."
42. _____ I get angry when I think about the ways I have been mistreated by other people throughout my life.
43. _____ Throughout my life, those close to me have taken advantage of me or used me for their own purposes.
44. _____ I have been physically, emotionally, or sexually abused by important people in my life.

*ma

45. _____ I don't fit in.
46. _____ I'm fundamentally different from other people.
47. _____ I don't belong; I'm a loner.
48. _____ I feel alienated from other people.
49. _____ I feel isolated and alone.
50. _____ I always feel on the outside of groups.
51. _____ No one really understands me.
52. _____ My family was always different from the families around us.
53. _____ I sometimes feel as if I'm an alien.
54. _____ If I disappeared tomorrow, no one would notice.

*si

55. _____ No man/woman I desire could love me one he/she saw my defects.
56. _____ No one I desire would want to stay close to me if he/she knew the real me.
57. _____ I am inherently flawed and defective.
58. _____ No matter how hard I try, I feel that I won't be able to get a significant man/woman to respect me or feel that I am worthwhile.
59. _____ I'm unworthy of the love, attention, and respect of others.
60. _____ I feel that I'm not lovable
61. _____ I am too unacceptable in very basic ways to reveal myself to other people.
62. _____ If others found out about my basic defects, I could not face them.
63. _____ When people like me, I feel I am fooling them.
64. _____ I often find myself drawn to people who are very critical or reject me.
65. _____ I have inner secrets that I don't want people close to me to find out.
66. _____ It is my fault that my parent(s) could not love me enough.

67. _____ I don't let people know the real me.

68. _____ One of my greatest fears is that my defects will be exposed.

69. _____ I cannot understand how anyone could love me.

*ds

70. _____ I'm not sexually attractive.

71. _____ I'm too fat.

72. _____ I'm ugly.

73. _____ I can't carry on a decent conversation.

74. _____ I'm dull and boring in social situations.

75. _____ People I value wouldn't associate with me because of my social status (e.g., income, educational level, career).

76. _____ I never know what to say socially.

77. _____ People don't want to include me in their groups.

78. _____ I am very self-conscious around other people.

*su

79. _____ Almost nothing I do at work (or school) is as good as other people can do.

80. _____ I'm incompetent when it comes to achievement.

81. _____ Most other people are more capable than I am in areas of work and achievement.

82. _____ I'm a failure.

83. _____ I'm not as talented as most people are at their work.

84. _____ I'm not as intelligent as most people when it comes to work (or school).

85. _____ I am humiliated by my failures and inadequacies in the work sphere.

86. _____ I often feel embarrassed around other people because I don't measure up to them in terms of my accomplishments.

87. _____ I often compare my accomplishments with others and feel that they are much more successful.

*fa

88. _____ I do not feel capable of getting by on my own in everyday life.

89. _____ I need other people to help me get by.

90. _____ I do not feel I can cope well by myself.

91. _____ I believe that other people can take care of me better than I can take care of myself.

92. _____ I have trouble tackling new tasks outside of work unless I have someone to guide me.

93. _____ I think of myself as a dependent person, when it comes to everyday functioning.

94. _____ I screw up everything I try, even outside of work (or school).

95. _____ I'm inept in most areas of life.

96. _____ If I trust my own judgment in everyday situations, I'll make the wrong decision.

97. _____ I lack common sense.

98. _____ My judgment cannot be relied upon in everyday situations.

99. _____ I don't feel confident about my ability to solve everyday problems that come up.

100. _____ I feel I need someone I can rely on to give me advice about practical issues.

101. _____ I feel more like a child than an adult when it comes to handling everyday responsibilities.

102. _____ I find the responsibilities of everyday life overwhelming.

*di

103. _____ I can't seem to escape the feeling that something bad is about to happen.

104. _____ I feel that a disaster (natural, criminal, financial, or medical) could strike at any moment.

105. _____ I worry about becoming a street person or vagrant.

106. _____ I worry about being attacked.
107. _____ I feel that I must be very careful about money, or else I might end up with nothing.
108. _____ I take great precautions to avoid getting sick or hurt.
109. _____ I worry that I'll lose all my money and become destitute.
110. _____ I worry that I'm developing a serious illness, even though nothing serious has been diagnosed by a physician.
111. _____ I am a fearful person.
112. _____ I worry a lot about the bad things happening in the world: crime, pollution, etc.
113. _____ I often feel that I might go crazy.
114. _____ I often feel that I'm going to have an anxiety attack.
115. _____ I often worry that I might have a heart attack, even though there is little medical reason to be concerned.
116. _____ I feel that the world is a dangerous place.
- *vh
117. _____ I have not been able to separate myself from my parent(s), the way other people my age seem to.
118. _____ My parent(s) and I tend to be overinvolved in each other's lives and problems.
119. _____ It is very difficult for my parent(s) and me to keep intimate details from each other, without feeling betrayed or guilty.
120. _____ My parent(s) and I have to speak to each other almost every day or else one of us feels guilty, hurt, disappointed, or alone.
121. _____ I often feel that I do not have a separate identity from my parent(s) or partner.
122. _____ I often feel as if my parent(s) are living through me -- I don't have a life of my own.
123. _____ It is very difficult for me to maintain any distance from the people I am intimate with; I have trouble keeping any separate sense of myself.

124. _____ I am so involved with my partner or parent(s) that I do not really know who I am or what I want.

125. _____ I have trouble separating my point of view or opinion from that of my parent(s) or partner.

126. _____ I often feel that I have no privacy when it comes to my parent(s) or partner.

127. _____ I feel that my parent(s) are, or would be, very hurt about my living on my own, away from them.

*em

128. _____ I let other people have their way, because I fear the consequences.

129. _____ I think that if I do what I want, I'm only asking for trouble.

130. _____ I feel that I have no choice but to give in to other people's wishes, or else they will retaliate or reject me in some way.

131. _____ In relationships, I let the other person have the upper hand.

132. _____ I've always let others make choices for me, so I really don't know what I want for myself.

133. _____ I feel the major decisions in my life were not really my own.

134. _____ I worry a lot about pleasing other people so they won't reject me.

135. _____ I have a lot of trouble demanding that my rights be respected and that my feelings be taken into account.

136. _____ I get back at people in little ways instead of showing my anger.

137. _____ I will go to much greater lengths than most people to avoid confrontations.

*sb

138. _____ I put others' needs before my own, or else I feel guilty.

139. _____ I feel guilty when I let other people down or disappoint them.

140. _____ I give more to other people than I get back in return.

141. _____ I'm the one who usually ends up taking care of the people I'm close to.

142. _____ There is almost nothing I couldn't put up with if I loved someone.

143. _____ I am a good person because I think of others more than of myself.
144. _____ At work, I'm usually the one to volunteer to do extra tasks or to put in extra time.
145. _____ No matter how busy I am, I can always find time for others.
146. _____ I can get by on very little, because my needs are minimal.
147. _____ I'm only happy when those around me are happy.
148. _____ I'm so busy doing for the people that I care about, that I have little time for myself.
149. _____ I've always been the one who listens to everyone else's problems.
150. _____ I'm more comfortable giving a present than receiving one.
151. _____ Other people see me as doing too much for others and not enough for myself.
152. _____ No matter how much I give, it is never enough.
153. _____ If I do what I want, I feel very uncomfortable.
154. _____ It's very difficult for me to ask others to take care of my needs.
- *ss
155. _____ I worry about losing control of my actions.
156. _____ I worry that I might seriously harm someone physically or emotionally if my anger gets out of control.
157. _____ I feel that I must control my emotions and impulses, or something bad is likely to happen.
158. _____ A lot of anger and resentment build up inside of me that I don't express.
159. _____ I am too self-conscious to show positive feelings to others (e.g., affection, showing I care).
160. _____ I find it embarrassing to express my feelings to others.
161. _____ I find it hard to be warm and spontaneous.
162. _____ I control myself so much that people think I am unemotional.
163. _____ People see me as uptight emotionally.

*ei

164. _____ I must be the best at most of what I do; I can't accept second best.
165. _____ I strive to keep almost everything in perfect order.
166. _____ I must look my best most of the time.
167. _____ I try to do my best; I can't settle for "good enough."
168. _____ I have so much to accomplish that there is almost no time to really relax.
169. _____ Almost nothing I do is quite good enough; I can always do better.
170. _____ I must meet all my responsibilities.
171. _____ I feel there is constant pressure for me to achieve and get things done.
172. _____ My relationships suffer because I push myself so hard.
173. _____ My health is suffering because I put myself under so much pressure to do well.
174. _____ I often sacrifice pleasure and happiness to meet my own standards.
175. _____ When I make a mistake, I deserve strong criticism.
176. _____ I can't let myself off the hook easily or make excuses for my mistakes.
177. _____ I'm a very competitive person.
178. _____ I put a good deal of emphasis on money or status.
179. _____ I always have to be Number One, in terms of my performance.

*us

180. _____ I have a lot of trouble accepting "no" for an answer when I want something from other people.
181. _____ I often get angry or irritable if I can't get what I want.
182. _____ I'm special and shouldn't have to accept many of the restrictions placed on other people.
183. _____ I hate to be constrained or kept from doing what I want.
184. _____ I feel that I shouldn't have to follow the normal rules and conventions other people do.

185. _____ I feel that what I have to offer is of greater value than the contributions of others.

186. _____ I usually put my needs ahead of the needs of others.

187. _____ I often find that I am so involved in my own priorities that I don't have time to give to friends or family.

188. _____ People often tell me I am very controlling about the ways things are done.

189. _____ I get very irritated when people won't do what I ask of them.

190. _____ I can't tolerate other people telling me what to do.

*et

191. _____ I have great difficulty getting myself to stop drinking, smoking, overeating, or other problem behaviors.

192. _____ I can't seem to discipline myself to complete routine or boring tasks.

193. _____ Often I allow myself to carry through on impulses and express emotions that get me into trouble or hurt other people.

194. _____ If I can't reach a goal, I become easily frustrated and give up.

195. _____ I have a very difficult time sacrificing immediate gratification to achieve a long-range goal.

196. _____ It often happens that, once I start to feel angry, I just can't control it.

197. _____ I tend to overdo things, even though I know they are bad for me.

198. _____ I get bored very easily.

199. _____ When tasks become difficult, I usually cannot persevere and complete them.

200. _____ I can't concentrate on anything for too long.

201. _____ I can't force myself to do things I don't enjoy, even when I know it's for my own good.

202. _____ I lose my temper at the slightest offense.

203. _____ I have rarely been able to stick to my resolutions.

204. _____ I can almost never hold back from showing people how I really feel, no matter what the cost may be.

205. _____ I often do things impulsively that I later regret.

***is**

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YSQ - S2

Name _____

Date _____

INSTRUCTIONS:

Listed below are statements that a person might use to describe himself or herself. Please read each statement and decide how well it describes you. When there you are not sure, base your answer on what you emotionally **feel**, not on what you **think** to be true. Choose the **highest rating from 1 to 6** that describes you and write the number in the space before the statement.

RATING SCALE:

1 = Completely untrue of me

2 = Mostly untrue of me

3 = Slightly more true than untrue

4 = Moderately true of me

5 = Mostly true of me

6 = Describes me perfectly

1. _____ Most of the time, I haven't had someone to nurture me, share him/herself with me, or care deeply about everything that happens to me.
2. _____ In general, people have not been there to give me warmth, holding, and affection.
3. _____ For much of my life, I haven't felt that I am special to someone.
4. _____ For the most part, I have not had someone who really listens to me, understands me, or is tuned into my true needs and feelings.
5. _____ I have rarely had a strong person to give me sound advice or direction when I'm not sure what to do.

*ed

6. _____ I find myself clinging to people I'm close to, because I'm afraid they'll leave me.

7. _____ I need other people so much that I worry about losing them.

8. _____ I worry that people I feel close to will leave me or abandon me.

9. _____ When I feel someone I care for pulling away from me, I get desperate.

10. _____ Sometimes I am so worried about people leaving me that I drive them away.

***ab**

11. _____ I feel that people will take advantage of me.

12. _____ I feel that I cannot let my guard down in the presence of other people, or else they will intentionally hurt me.

13. _____ It is only a matter of time before someone betrays me.

14. _____ I am quite suspicious of other people's motives.

15. _____ I'm usually on the lookout for people's ulterior motives.

***ma**

16. _____ I don't fit in.

17. _____ I'm fundamentally different from other people.

18. _____ I don't belong; I'm a loner.

19. _____ I feel alienated from other people.

20. _____ I always feel on the outside of groups.

***si**

21. _____ No man/woman I desire could love me one he/she saw my defects.

22. _____ No one I desire would want to stay close to me if he/she knew the real me.

23. _____ I'm unworthy of the love, attention, and respect of others.

24. _____ I feel that I'm not lovable.

25. _____ I am too unacceptable in very basic ways to reveal myself to other people.

***ds**

26. _____ Almost nothing I do at work (or school) is as good as other people can do.

27. _____ I'm incompetent when it comes to achievement.

28. _____ Most other people are more capable than I am in areas of work and achievement.

29. _____ I'm not as talented as most people are at their work.

30. _____ I'm not as intelligent as most people when it comes to work (or school).

*fa

31. _____ I do not feel capable of getting by on my own in everyday life.

32. _____ I think of myself as a dependent person, when it comes to everyday functioning.

33. _____ I lack common sense.

34. _____ My judgment cannot be relied upon in everyday situations.

35. _____ I don't feel confident about my ability to solve everyday problems that come up.

*di

36. _____ I can't seem to escape the feeling that something bad is about to happen.

37. _____ I feel that a disaster (natural, criminal, financial, or medical) could strike at any moment.

38. _____ I worry about being attacked.

39. _____ I worry that I'll lose all my money and become destitute.

40. _____ I worry that I'm developing a serious illness, even though nothing serious has been diagnosed by a physician.

*vh

41. _____ I have not been able to separate myself from my parent(s), the way other people my age seem to.

42. _____ My parent(s) and I tend to be overinvolved in each other's lives and problems.

43. _____ It is very difficult for my parent(s) and me to keep intimate details from each other, without feeling betrayed or guilty.

44. _____ I often feel as if my parent(s) are living through me--I don't have a life of my own.

45. _____ I often feel that I do not have a separate identity from my parent(s) or partner.

*em

46. _____ I think that if I do what I want, I'm only asking for trouble.

47. _____ I feel that I have no choice but to give in to other people's wishes, or else they will retaliate or reject me in some way.

48. _____ In relationships, I let the other person have the upper hand.

49. _____ I've always let others make choices for me, so I really don't know what I want for myself.

50. _____ I have a lot of trouble demanding that my rights be respected and that my feelings be taken into account.

*sb

51. _____ I'm the one who usually ends up taking care of the people I'm close to.

52. _____ I am a good person because I think of others more than of myself.

53. _____ I'm so busy doing for the people that I care about, that I have little time for myself.

54. _____ I've always been the one who listens to everyone else's problems.

55. _____ Other people see me as doing too much for others and not enough for myself.

*ss

56. _____ I am too self-conscious to show positive feelings to others (e.g., affection, showing I care).

57. _____ I find it embarrassing to express my feelings to others.

58. _____ I find it hard to be warm and spontaneous.

59. _____ I control myself so much that people think I am unemotional.

60. _____ People see me as uptight emotionally.

*ei

61. _____ I must be the best at most of what I do; I can't accept second best.
62. _____ I try to do my best; I can't settle for "good enough."
63. _____ I must meet all my responsibilities.
64. _____ I feel there is constant pressure for me to achieve and get things done.
65. _____ I can't let myself off the hook easily or make excuses for my mistakes.

*us

66. _____ I have a lot of trouble accepting "no" for an answer when I want something from other people.
67. _____ I'm special and shouldn't have to accept many of the restrictions placed on other people.
68. _____ I hate to be constrained or kept from doing what I want.
69. _____ I feel that I shouldn't have to follow the normal rules and conventions other people do.
70. _____ I feel that what I have to offer is of greater value than the contributions of others.

*et

71. _____ I can't seem to discipline myself to complete routine or boring tasks.
72. _____ If I can't reach a goal, I become easily frustrated and give up.
73. _____ I have a very difficult time sacrificing immediate gratification to achieve a long-range goal.
74. _____ I can't force myself to do things I don't enjoy, even when I know it's for my own good.
75. _____ I have rarely been able to stick to my resolutions.

*is

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Early Maladaptive Schemas

and Schema Domains

**(Note: The 5 Schema Domains are centered on the page;
the 18 Early Maladaptive Schemas are numbered along the left-hand
margin.)**

DISCONNECTION & REJECTION

(Expectation that one's needs for security, safety, stability, nurturance, empathy, sharing of feelings, acceptance, and respect will not be met in a predictable manner. Typical family origin is detached, cold, rejecting, withholding, lonely, explosive, unpredictable, or abusive.)

1. ABANDONMENT / INSTABILITY (AB)

The perceived instability or unreliability of those available for support and connection.

Involves the sense that significant others will not be able to continue providing emotional support, connection, strength, or practical protection because they are emotionally unstable and unpredictable (e.g., angry outbursts), unreliable, or erratically present; because they will die imminently; or because they will abandon the patient in favor of someone better.

2. MISTRUST / ABUSE (MA)

The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. Usually involves the perception that the harm is intentional or the result of unjustified and extreme negligence. May include the sense that one always ends up being cheated relative to others or "getting the short end of the stick."

3. EMOTIONAL DEPRIVATION (ED)

Expectation that one's desire for a normal degree of emotional support will not be adequately met by others. The three major forms of deprivation are:

A. Deprivation of Nurturance: Absence of attention, affection, warmth, or companionship.

B. Deprivation of Empathy: Absence of understanding, listening, self-disclosure, or mutual sharing of feelings from others.

C. Deprivation of Protection: Absence of strength, direction, or guidance from others.

4. DEFECTIVENESS / SHAME (DS)

The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects; or that one would be unlovable to significant others if exposed. May involve hypersensitivity to criticism, rejection, and blame; self-consciousness, comparisons, and insecurity around others; or a sense of shame regarding one's perceived flaws. These flaws may be private (e.g., selfishness, angry impulses, unacceptable sexual desires) or public (e.g., undesirable physical appearance, social awkwardness).

5. SOCIAL ISOLATION / ALIENATION (SI)

The feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.

IMPAIRED AUTONOMY & PERFORMANCE

(Expectations about oneself and the environment that interfere with one's perceived ability to separate, survive, function independently, or perform successfully. Typical family origin is enmeshed, undermining of child's confidence, overprotective, or failing to reinforce child for performing competently outside the family.)

6. DEPENDENCE / INCOMPETENCE (DI)

Belief that one is unable to handle one's everyday responsibilities in a competent manner, without considerable help from others (e.g., take care of oneself, solve daily problems, exercise good judgment, tackle new tasks, make good decisions). Often presents as helplessness.

7. VULNERABILITY TO HARM OR ILLNESS (VH)

Exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it. Fears focus on one or more of the following: (A) Medical Catastrophes: e.g., heart attacks, AIDS; (B) Emotional Catastrophes: e.g., going crazy; (C): External Catastrophes: e.g., elevators collapsing, victimized by criminals, airplane crashes, earthquakes.

8. ENMESHMENT / UNDEVELOPED SELF (EM)

Excessive emotional involvement and closeness with one or more significant others (often parents), at the expense of full individuation or normal social development. Often involves the belief that at least one of the enmeshed individuals cannot survive or be happy without the constant support of the other. May also include feelings of being smothered by, or fused with, others OR insufficient individual identity. Often experienced as a feeling of emptiness and floundering, having no direction, or in extreme cases questioning one's existence.

9. FAILURE (FA)

The belief that one has failed, will inevitably fail, or is fundamentally inadequate relative to one's peers, in areas of achievement (school, career, sports, etc.). Often involves beliefs that one is stupid, inept, untalented, ignorant, lower in status, less successful than others, etc.

IMPAIRED LIMITS

(Deficiency in internal limits, responsibility to others, or long-term goal-orientation. Leads to difficulty respecting the rights of others, cooperating with others, making commitments, or setting and meeting realistic personal goals. Typical family origin is characterized by permissiveness, overindulgence, lack of direction, or a sense of superiority -- rather than appropriate confrontation, discipline, and limits in relation to taking responsibility, cooperating in a reciprocal manner, and setting goals. In some cases, child may not have been pushed to tolerate normal levels of discomfort, or may not have been given adequate supervision, direction, or guidance.)

10. ENTITLEMENT / GRANDIOSITY (ET)

The belief that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interaction. Often involves insistence that one should be able to do or have whatever one wants, regardless of what is realistic, what others consider reasonable, or the cost to others; OR an exaggerated focus on superiority (e.g., being among the most successful, famous, wealthy) -- in order to achieve power or control (not primarily for attention or approval). Sometimes includes excessive competitiveness toward, or domination of, others: asserting one's power, forcing one's point of view, or controlling the behavior of others in line with one's own desires---without empathy or concern for others' needs or feelings.

11. INSUFFICIENT SELF-CONTROL / SELF-DISCIPLINE (IS)

Pervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance to achieve one's personal goals, or to restrain the excessive expression of one's emotions and impulses. In its milder form, patient presents with an exaggerated emphasis on discomfort-avoidance: avoiding pain, conflict, confrontation, responsibility, or overexertion---at the expense of personal fulfillment, commitment, or integrity.

OTHER-DIRECTEDNESS

(An excessive focus on the desires, feelings, and responses of others, at the expense of one's own needs -- in order to gain love and approval, maintain one's sense of connection, or avoid retaliation. Usually involves suppression and lack of awareness regarding one's own anger and natural inclinations. Typical family

origin is based on conditional acceptance: children must suppress important aspects of themselves in order to gain love, attention, and approval. In many such families, the parents' emotional needs and desires -- or social acceptance and status -- are valued more than the unique needs and feelings of each child.)

12. SUBJUGATION (SB)

Excessive surrendering of control to others because one feels coerced - - usually to avoid anger, retaliation, or abandonment. The two major forms of subjugation are:

A. Subjugation of Needs: Suppression of one's preferences, decisions, and desires.

B. Subjugation of Emotions: Suppression of emotional expression, especially anger.

Usually involves the perception that one's own desires, opinions, and feelings are not valid or important to others. Frequently presents as excessive compliance, combined with hypersensitivity to feeling trapped. Generally leads to a build up of anger, manifested in maladaptive symptoms (e.g., passive-aggressive behavior, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, "acting out", substance abuse).

13. SELF-SACRIFICE (SS)

Excessive focus on voluntarily meeting the needs of others in daily situations, at the expense of one's own gratification. The most common reasons are: to prevent causing pain to others; to avoid guilt from feeling selfish; or to maintain the connection with others perceived as needy . Often results from an acute sensitivity to the pain of others. Sometimes leads to a sense that one's own needs are not being adequately met and to resentment of those who are taken care of. (Overlaps with concept of codependency.)

OVERVIGILANCE & INHIBITION

(Excessive emphasis on suppressing one's spontaneous feelings, impulses, and choices OR on meeting rigid, internalized rules and expectations about performance and ethical behavior -- often at the expense of happiness, self-expression, relaxation, close relationships, or health. Typical family origin is grim, demanding, and sometimes punitive: performance, duty, perfectionism, following rules, hiding emotions, and avoiding mistakes predominate over pleasure, joy, and relaxation. There is usually an undercurrent of pessimism and worry---that things could fall apart if one fails to be vigilant and careful at all times.)

14. EMOTIONAL INHIBITION (EI)

The excessive inhibition of spontaneous action, feeling, or communication -- usually to avoid disapproval by others, feelings of shame, or losing control of

one's impulses. The most common areas of inhibition involve: (a) inhibition of anger & aggression; (b) inhibition of positive impulses (e.g., joy, affection, sexual excitement, play); (c) difficulty expressing vulnerability or communicating freely about one's feelings, needs, etc.; or (d) excessive emphasis on rationality while disregarding emotions.

15. UNRELENTING STANDARDS / HYPERCRITICALNESS (US)

The underlying belief that one must strive to meet very high internalized standards of behavior and performance, usually to avoid criticism. Typically results in feelings of pressure or difficulty slowing down; and in hypercriticalness toward oneself and others. Must involve significant impairment in: pleasure, relaxation, health, self-esteem, sense of accomplishment, or satisfying relationships.

Unrelenting standards typically present as: (a) perfectionism, inordinate attention to detail, or an underestimate of how good one's own performance is relative to the norm; (b) rigid rules and "shoulds" in many areas of life, including unrealistically high moral, ethical, cultural, or religious precepts; or (c) preoccupation with time and efficiency, so that more can be accomplished.

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Appendix 7

Sample Vignettes

Abuse History

19 Background Information

Q is a 37 year old, single Afro-Caribbean woman. She left school at age 16 after her O-levels and has since worked in security and cleaning. For the past few years, she has worked as a receptionist and reports that her colleagues are very supportive of her mental health difficulties. She has never misused alcohol or drugs. She had her first psychotic episode 3 years ago. She has never had a psychiatric admission.

Abuse History

Q's CTQ scores placed her on the severe range for emotional and sexual abuse. In addition her scores indicated a moderate level of physical abuse.

Q was not able to disclose the identity of the perpetrator of her abuse at interview, however she was able to write answers to questions indicating that the abuse started at age 6 and continued until aged 12, happening approximately weekly and involving full sexual intercourse.

Schemas

1 Participant 1 highly endorsed the following schemas:

Emotional Deprivation

Social Isolation

Vulnerability

Delusions

D

A large, empty rectangular box with a thin black border, occupying most of the page. It is intended for the user to write their response to the question 'D'.

Appendix 8

Instructions to Panels

Thank you very much for taking part in this research which I gather has been explained by Oliver Mason. In brief, we are looking into the link between childhood abuse, schemas and delusions in adulthood. We are hoping to find out whether certain types of abuse lead to characteristic schemas and delusions.

Participants for this research were interviewed and given a number of questionnaires. The information gathered was anonymised and converted into vignettes.

There are three vignettes for each participant:

1. **Background information and abuse history**
2. **Schemas**
3. **Delusions**

Background Information and abuse history

Basic background information, such as age, marital status, occupational status, was collected from the participant at interview, as well as brief information regarding the duration of their psychosis.

The abuse history was largely ascertained through the Childhood Trauma Questionnaire (CTQ) (Bernstein & Fink, 1998). This 28 item questionnaire distinguishes abuse into five categories; physical, sexual and emotional abuse, and physical and emotional neglect. The CTQ separates abuse experience by severity, and for the purposes of this research participants were required to score in the moderate to severe levels of abuse for it to be included in the vignettes.

Following the administration of the CTQ, additional questions were asked, for example, to identify the perpetrator of the abuse, and the period of time in which it occurred. This information is provided in the vignette.

Schemas

Participants were asked to complete either the short or the long form of the Young Schema Questionnaire (YSQ)(Young, 1999). The choice of which questionnaire to use was purely practical. The 205 item long form and 75 item short form assess the extent to which a person holds a number of 'Early Maladaptive Schemas'. Young defines Early Maladaptive Schemas as: "broad, pervasive themes regarding oneself and one's relationship with others, developed during childhood and elaborated throughout one's lifetime, and dysfunctional to a significant degree."

The YSQ is a clinical tool and there are no formal scoring criteria. Therefore, a person was seen to highly endorse a schema with a score of over 75%. This cut-off was felt to discriminate our sample.

The schema vignettes list the schemas which a participant highly endorsed. Please see the attached sheet for more detailed descriptions of the schemas (Young, 2003).

In order to prevent the identification of individuals, the initials have been replaced with a randomly generated number and the gender or background information has not been disclosed.

Delusions

In order to systematically obtain an account of a participant's delusional beliefs and other psychotic symptoms, interviewers used a semi-structured interview protocol based on the SCAN. Directly after the interview, a summary was written by the researcher, which was checked and signed by the participant. For most vignettes the participants reported a number of areas of concern and these are recorded in the order of their importance.

In order to prevent the identification of individuals, the vignettes have been randomly assigned a numeric marker and identifying details may have been removed. In order to prevent matching by gender, and for ease of reading participants have been allocated letters to substitute for pronouns. These have been allocated alphabetically and bear no relation to the initials provided for the background history.

PLEASE DO NOT OPEN ENVELOPE 2 BEFORE COMPLETING TASK ONE

Task One (Envelope 1):

In this task you are being asked to distinguish individuals who reported sexual abuse, from those who reported other forms or combinations of abuse (physical, emotional or neglect). There are 8 vignettes provided for each category.

- Please read the schema vignettes and separate into those which you think result from **sexual** abuse and those which you think arise from a combination of other forms of abuse (i.e. physical, emotional or neglect)
- Please read the delusion vignettes and separate into those which you think belong to a participant who has experienced sexual abuse and those which you think belong to a participant who has experienced a combination of other forms of abuse (i.e. physical, emotional and neglect)

Task Two (Envelope 2):

In this task you have been given the abuse history, schema and delusion vignettes for 8 participants who have experienced sexual abuse. Please read the vignettes and attempt to place the vignettes together for each participant (their abuse history, schema and delusion).

Please use the space below for any thoughts you have about these tasks.

It would be useful for us to know about what informed your decisions – the hints or clues in the vignettes that were particularly salient. We would also welcome feedback about the tasks and vignettes.

Many thanks