

**Childhood Physical Abuse and Delusional
Content**

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Overview

This study investigates the links between physical abuse experienced in childhood and the influence it has on the content of delusional beliefs formed later in life. Part one reviews the literature regarding the prevalence and impact of childhood abuse throughout the life cycle. In considering the impact of abuse, the review is divided into sections on childhood, adolescence and adulthood. It then goes on to consider the research regarding the influence of early abusive experiences on psychosis and delusions.

Part two of this study presents an empirical paper describing the research undertaken. Data was obtained from 15 participants with a history of delusional beliefs who had experienced physical abuse as a child. A thematic analysis was conducted to explore the emerging themes, and independent expert raters were asked to distinguish delusional beliefs and schemas based on the information regarding early experience. Themes regarding threats from others, a badness of self, religious and spiritual themes, special abilities or status and issues of control emerged in the thematic analysis. Results from the expert raters indicated an inability to reliably distinguish delusions on the basis of early abuse experience. In addition there appeared to be a potentially misleading effect of the schema information, which may suggest a defensive role of the delusional beliefs reported.

The final part of this study reflects upon the process of the research, considering the design, chosen methodology, and clinical and service implications.

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CHILDHOOD PHYSICAL ABUSE AND DELUSIONAL CONTENT – A REVIEW OF THE LITERATURE

ABSTRACT

This review will consider the literature regarding the prevalence and impact of childhood physical abuse, and the potential link to the formation of delusions later in life. Childhood physical abuse is linked to a number of psychological difficulties both within childhood and later in the life cycle. As psychological models have increasingly been applied to psychosis (and delusional beliefs in particular) the role of early experience has increasingly been considered central. Given the high prevalence of past abusive experiences in individuals with psychosis, and the potentially far reaching effects of this abuse and resulting posttraumatic stress symptoms, further research is recommended to consider the role of abuse in order to improve clinical practice with these individuals.

INTRODUCTION

Delusions are defined as a “false personal belief based on incorrect inference about external reality”, held despite evidence to the contrary, and despite the belief not “ordinarily being accepted by other members of the person’s culture or subculture” (American Psychiatric Association, 1994, p.765).

They were traditionally regarded by the medical model as a symptom of psychotic illness, and by definition meaningless and unworthy of investigation. Over time advances in the understanding of psychosis and the development of the cognitive model has challenged this stance. The application of the cognitive model to the more severe forms of psychopathology has suggested that the content of delusions are not only relevant, but also modifiable in a manner that can impact the outcome and recovery of psychosis.

In investigating the possibilities for working with individuals with delusions, it has been recognised by clinicians that early experience as well as stressful life events appear to contribute to their aetiology. It has particularly been noted that individuals with these more severe mental health problems are more likely to report abuse histories, increasing the research into the potential links between these experiences.

This review will focus on childhood physical abuse as a contributor to the formation of delusional beliefs. In order to consider this link, the review will firstly consider physical abuse, its definition and prevalence, and the links to corporal punishment. In the second section the review will present the theoretical models and empirical evidence for the

psychological impact of physical abuse. In section three the review will present the research ideas regarding the role of physical abuse in the development of delusions. Finally the review will conclude in section four with a consideration of the difficulties of research in this area and areas of debate.

SECTION 1: CHILDHOOD PHYSICAL ABUSE

Physical abuse has been defined in its simplest form as referring to ‘deliberately inflicted injury or deliberate attempts to poison a child’ (Carr, 1999). A checklist of items that may raise suspicion of physical abuse in the same chapter asks the clinician to consider the history of injuries, the account provided of the recent injury, the parents relationship with the assessment team and any supporting evidence for abuse in addition to a careful review of the injury itself. It is beyond doubt that the injuries sustained in physical abuse can be serious and life threatening, and that in the short term any child is likely to experience psychological difficulties in addition to the physical injuries sustained. In this section the review will consider the legal position on childhood physical abuse, its prevalence, causes and the links to corporal punishment.

Section 1.1 - The legal position

In 1989 the United Nations made a Declaration on the Rights of the Child stating clearly “the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before and after birth”. This statement further made explicit a number of areas in which a child may require protection. It specifies abuse in Article 19 ensuring that countries shall take “all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse” (1989)

In the same year the United Kingdom passed its own Children’s Act (1989) which states clearly the authority of the court to intervene where the court is satisfied that an

applicant has reasonable cause to suspect that the child is suffering, or is likely to suffer, significant harm. The Act additionally ensures an assessment of the state of the child's health or development, and of the way in which the child has been treated can also be conducted under court order if necessary.

Further to ensuring the immediate protection of a child in danger, there are additional legislative measures within the Children's Act (1989) that comply with the UN recommendation that processes for identification, reporting, referral, investigation, treatment and follow up of instances of child maltreatment are in place.

Within the United Kingdom this has resulted in the establishment of Child Protection Registers, in order to ensure that children who are considered to be in need of protection are monitored and protected from abuse. The registers classify abuse into five commonly accepted categories: Physical abuse, sexual abuse, emotional abuse, emotional neglect and physical neglect. Physical abuse, which is the focus of this work, is stated to involve "hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing harm to a child" (Department of Health, 1999). Although Munchausen's By Proxy will not be the focus of this work, it is additionally registered under physical abuse, since the parent or carer feigns the symptoms of, or deliberately causes ill health in the child, which is likely to have physical consequences.

Section 1.2 - Prevalence of abuse:

National statistics from Her Majesty's Stationary Office cite 26,600 children on Child Protection Registers (year ending March 2003) with 19% of these registrations relating to physical abuse. Any child under the age of 18 may be registered, however just 2% of registrations are concerned with children over the age of 16, whereas 11% of registrations occur either before the child's birth, or before they reach the end of their first year of life.

Clearly data on children who are registered reflects the tip of the iceberg when it comes to the number of children who are maltreated as they are growing up. A NSPCC survey of 18-24 yr olds reported a rate of 24% of respondent describing treatment that would fit with the definition of physical abuse (Cawson et al., 1999). This was based on definitions of 'serious abuse' equating to violent treatment on a regular basis, or violence causing serious injury or effects lasting to the next day. A situation where violent treatment was irregular was considered an 'intermediate' level of abuse and a further classification of 'cause for concern' was included.

In the writing of this report the NSPCC however highlight one of the difficulties in both defining childhood physical abuse, and in assessing its prevalence. Although 17% of respondents reported that the physical treatment they received was too harsh for a child, just 7% reported that they considered it abusive.

This difficulty arises since physical abuse lies within the bounds of normally accepted behaviour both historically and in modern times. Under British law it is currently

acceptable to hit a child on the grounds of providing 'reasonable chastisement'. This has become an issue of some debate as the United Nations Declaration of the Rights of the Child makes clear recommendations for the abolition of the practice of Corporal punishment at all levels of society, within the family and without. Despite 12 European countries successfully passing legislation to outlaw these practices, the English parliament remains in some debate at the current time of writing declining to accept an outright ban.

Section 1.3 - The Causes of Physical Abuse

Whipple, Webster and Stratton (1991) noted that parents who are physically abusive are more likely to be young, poorly educated, have low incomes and to abuse alcohol or drugs. These suggestions are supported by Pelton's (1994) findings of the links of chronic poverty, recent job loss, marital discord and social isolation to increased child abuse.

However, the debate regarding the causes for childhood abuse is wide ranging in its suggestion of contributing factors, Tzeng, Jackson and Karlson (1991) review describing 25 different theoretical approaches for physical abuse alone.

Coohey and Braun's (1997) review notes these attempts to explain childhood physical abuse and suggest a more integrated framework. They consider three main categories of contributing factors – perpetrator's exposure to aggression, exposure to stressors and their access to resources (knowledge, skills, financial support etc). The authors add to the model perpetrators' problem solving skills and their experience of being abused by a

partner to create an integrated framework with contributions from personal characteristics and experience, current environmental circumstances and problem solving processes.

However Belsky (1993) and Cicchetti and Toth (1993) are examples of scholars who view physical abuse as a social disease related to the acceptance of violence within families. This is supported by the empirical evidence of Zigler and Hall (1989) who report that most abuse occurs when parents attempt to discipline their children, and Belsky (1993) who notes the lowered rate of physical abuse in countries where corporal punishment is frowned upon.

Section 1.4 – The Role of Corporal punishment.

Straus defines corporal punishment as “the use of physical force with the intention of causing a child to experience pain, but not injury for the purposes of correction or control of the child’s behaviour” (1994 p.4). Gershoff 2002 cites this definition but further comments that many authors consider corporal punishment as one place on a continuum of physical violence towards children; with abusive acts not far away (Gelles & Straus, 1988; Graziano, 1994; Whipple & Richely, 1997).

Research into the effects of corporal punishment adds to the debate regarding its acceptability. Evidence suggests that it fails to teach the lessons that it intends, promoting children’s external attribution for their behaviour, failing to teach the effect of their behaviour on others, and promoting hostile attributions towards others (Hoffman, 1983; Patterson, 1982; Smetana, 1997). In addition the use of corporal punishment is

thought to model and legitimise violence (White & Strauss, 1981), increase children's aggression (Becker, 1964) and has been linked with the aetiology of criminal and anti-social behaviour.

A meta-analytic approach to the data set produced by Gershoff (2002) reports clearly that of the possible outcomes of corporal punishment, the only positive effect appeared to be the immediate (short term) cessation of the behaviour targeted. On the negative side however, children who are disciplined using physical punishment are reported to have decreased moral internalisation, increased childhood aggression, increased delinquent and anti-social behaviour, decreased quality of relationships with their parents, decreased childhood mental health, as well as increased adult aggression, increased adult criminality and anti-social behaviour and decreased adult mental health.

In support of the 'continuum' theory of corporal punishment to physical abuse, Gershoff additionally found significant data supporting the increased risk of childhood physical abuse in those children who were disciplined by corporal punishment, with an additional increased risk of abusing their own children or spouses as adults.

There is growing support within the UK for the establishment of the same rights to protection from violence for children in society, as there are for adults. This is backed not only by the United Nations Committee on the Rights of the Child, but by the Joint Committee on Human Rights in the UK who feel that the corporal punishment of children is a serious violation of the child's right to dignity and physical integrity.

Clearly as research into corporal punishment continues the debate over its use and the issues of physical abuse will continue, and the Amendments to the Children's Bill which at the time of writing is due in the next parliament will no doubt contribute to the debate.

SECTION 2: THE IMPACT OF PHYSICAL ABUSE IN CHILDHOOD & ADOLESCENCE

In order to consider the potential role of abuse in the development of psychological difficulties, this section of the literature review will present the empirical evidence and theoretical models regarding the impact of abuse in three parts. The first part considering the impact on the child, the second considering the impact on adolescents, and the third considering the impact of the experience of abuse which continues through to adulthood.

Section 2.1 Effects in Childhood

Empirical Evidence

The definitions of childhood physical abuse already reviewed give an indication of the type of physical injuries that result from these experiences. On a psychological level research has investigated children with reported experiences of physical abuse to consider the development of specific trauma related symptoms. The most immediately apparent example of this is the development of posttraumatic stress disorder.

In 2003 Lubitt and colleagues published a review of the research on the impact of trauma on children. They highlight how regression and loss of skills may be a symptom of the withdrawal and numbing that might be seen in adult PTSD. In addition intrusive memories may be represented in repetitive play with traumatic themes. They note that with older children (school age) symptoms of anxiety and hyper vigilance regarding future disasters and safety behaviours are common.

In more general terms Lubitt and colleagues also note a number of difficulties that appear to relate to the experience of trauma. They noted the common symptoms as fear, anhedonia, attention problems and learning difficulties in addition to new onset or recurrence of previous fears. Commonly children will display dependent behaviour; although where the abuse history is unknown the role of trauma in these symptoms is likely to go unrecognised.

These difficulties have been accounted for in a number of different psychological theories. Lubitt and colleagues present a review of data suggesting that many of these difficulties are in fact mislabelled as disorders, when they are in fact manifestations of posttraumatic stress disorder. Thereby symptoms such as hyperactivity and impulsivity, which may be posttraumatic attempts to maintain vigilance and control over the world, may be misinterpreted and treated as Attention Deficit Hyperactivity Disorder (ADHD). Similarly loss of control over aggression and impulses may appear to represent a conduct or oppositional defiant disorder, but may in fact have developed from their exposure to violence. This may have led to an increased acceptance of violence as a conflict resolution strategy, or to desires for revenge and retribution to balance the powerless experience of being a victim.

In addition to these potentially more short-term traumatic stress symptoms, in the longer term, a number of changes have been noted between the psychological characteristics of children who have experienced abuse and those who have not.

The empirical papers presented by Friedman et al. (2002) and Owens and Chard (2003) note the increased levels of internalising difficulties such as anxiety, depression, low self-esteem, and obsessive-compulsive disorders, although the latter study focused on the experience of sexual abuse, rather than physical. A number of research studies have highlighted the sad, fearful and frequently angry characteristics of maltreated infants (Toth & Cicchetti, 1993), their difficulties with peer relationships and aggression (Haskett & Kistner, 1991, Salzinger et al, 1993) and school failure (Eckenrode, Laird & Doris 1993). In addition internal psychological characteristics such as difficulties in emotional regulation, shame and guilt, development of empathy and prosocial behaviour have all been noted (Osofsky, 1994).

Using observational data to compare to their peer group, Salzinger et al. (1993) and Dodge (1994) have also noted an increase in aggression, difficulties in negotiating conflict, hyperactivity, impulsivity, difficulties in concentration and conduct disorders in those with experiences of physical abuse. In addition Price and Glad's (2003) study noted the significantly increased likelihood of perceiving ambiguous stimuli as hostile in children who have been physically abused.

It seems likely that these types of difficulties represent the child's chosen strategies for coping with overwhelming affect. It is thought that these difficulties, expressing in the medium term after the experience of a trauma, may impact upon the emerging personality of the child, creating vulnerabilities that may then express in later developmental stages through adolescence and beyond.

In addition to these difficulties in the developmental experiences of the child, there is increasing evidence for the neurological impact of trauma on the developing brain. With respect to Childhood Physical Abuse, there is a clear likelihood of physical damage as a result of head injury and/or shaking. In addition to this immediate physical risk, throughout the 1990's increasing empirical evidence for neurochemical changes as well as changes in the functioning of the structures of the brain have been published. These have suggested a role of stress hormones in increasing the latter risk of psychopathology. (Bremer, Randall & Scott, 1995; Bremer, Randall, Vermetten et al., 1997; Liu, Diorio, Tannenbaum et al., 1997; Teicher, Glod, Surrey et al., 1993).

It is also relevant to note the secondary traumatisation experienced by many children when disclosing abuse. This is particularly pertinent for disclosure of childhood physical abuse, since the ongoing intervention by authorities may require separation of the child from caregivers, or result in family disintegration. In addition to this, children may also find where they remain with caregivers, that these adults are concerned and preoccupied with guilt over failure to protect this child, or in the case of widespread family violence, may be coping with their own traumatic stress response. It seems clear that this will further disrupt the child's ability to cope with their experience of trauma, and to negotiate the developmental tasks that they are faced with at that stage of their life.

Theoretical models of effects in childhood

From the evidence presented above, it is clear that there are established effects of childhood abuse, which appear likely to set the scene for difficulties in adulthood. The

theoretical links of this developmental path will be presented here, before the review continues to consider the impact of abuse on the adolescent.

Early Freudian writings suggest “the child is psychologically father to the adult, and that the events of the first years are of paramount important for his whole later life” (Freud, 1940a p.187). This idea is continued in the writings of psychodynamic and developmental theorists who postulate that the impact of physical abuse on the attachment of the infant to its caregivers is likely to have a profound effect.

From a developmental perspective, trauma is noted to impact on the attachment style of children. Authors such as Trickkett and McBride-Chang (1995) report the likelihood of disturbed attachment and their review notes the differing impact of abuse on development through different stages of childhood.

In 1993, Toth and Cicchetti’s study noted that infants who are maltreated are more likely to have an avoidant attachment style, arising from their early environment. Within psychodynamic thinking, the attachment experience would be considered central to the child’s later life, providing a framework for all interpersonal relationships, and the child’s view of the world.

Supporting this notion Weinstein, Staffelbach, and Biaggio (2000) suggest a pivotal role of stress related to traumatic experiences which not only impact on a parent’s ability to care for child but also affect how well that child is able to form an attachment.

In addition the maintenance of the attachment is also likely to be affected by trauma. For the child in normal development, we would expect a slow adaptation to parental limitations, which prevents a sudden weakening of attachment. If their image of the parent is suddenly relinquished by traumatic events, attachment may weaken, creating anxiety and withdrawal, alongside a search for new figures to identify with and an ongoing difficulty in trusting these new attachments.

A number of empirical papers have linked attachment styles with later psychopathology; Warren et al. (1997) marked the increased prevalence of anxiety symptoms for those children with resistant attachments. Similarly Ogawa et al. (1997) notes the link between disorganised infants and dissociative symptoms and Weinfield et al. (1999) establishing that avoidant infants have the highest rates of disorders later in life.

These altered attachment styles reveal much of the route through which children who experience physical abuse may experience later difficulties in adjustment and development. Without a secure base from which to explore the world, or successfully negotiate life stage tasks, the child may develop personality characteristics, such as attribution style or cognitions, which remain with them through adolescence and beyond.

Section 2.2 Effects in Adolescence

Evidence of Effects in Adolescence

The immediate impact of physical abuse during adolescence may be similar to that during childhood, with frequently reported traumatic stress reactions. A number of authors suggest that difficulties emerge in adolescence as a result of traumatisation as

children. Strauss and colleagues' study in particular noted the occurrence of dissociation, depression, aggression, suicidal behaviour, aggression and anxiety in adolescents who were abused as children (1994).

Compared to younger children, adolescents may be more able to report difficulties, and developmentally they may have a wider range of coping strategies at their disposal. However, adolescents may be significantly more likely to express their distress in externalising problems such as risk taking, aggression or delinquency, or internalising problems that may endure to adulthood such as depression, dysthymia or anxiety.

Moran et al. (2004) report that the deficits in cognitive, social, emotional and behavioural functioning leads to problematic behaviours such as risk taking, poor academic functioning and negative peer relationships and in this study the authors particularly focus on how this increases difficulties with substances and addiction. Flisher, Kramer, Hoven and Greenwald (1997) provide evidence of the greater association with overall adjustment difficulties, poorer social competence, decreased language ability and poorer school performance with adolescents who have been physically abused.

Furthermore since adolescents are involved in a number of systems, empirical research by authors such as Meyerson et al. (2002) have considered how the family environment may impact on the psychological adjustment of adolescents. They found that children who had experienced abuse were more likely to perceive their family environment as

conflictual and non-cohesive, which in addition to a history of either physical or sexual abuse predicted depression and distress.

In addition coping strategy selection may be effected. This occurs not only by gender and social support factors, but is equally influenced by the adolescents' sense of self-control and their appraisal process, which is influenced by their previous or ongoing experiences of abuse. Williams (1993) suggests that this explains some of the resilience that is often seen to emerge at this time of life. For some adolescents, their manner of perceptions, appraisal and processing of the experience may lead to differing outcomes from others with similar childhood experiences, allowing them to overcome their experiences of abuse, or creating different outcomes in later life.

As noted with children of a younger age, adolescents may also face significant difficulties resulting from the disclosure of abuse. Adolescents too may experience disruption in family systems or support from the disclosure, and may also feel the impact on their developing sense of identity and peer relationships. Their ability to gain support from their peers may reflect an important element of successfully negotiating adolescence, although as we have seen, they may lack essential skills in this area, hampering their attempts.

Theoretical Models of the Impact of Abuse in Adolescence

In adolescence the theoretical explanations for psychological difficulties focus more on the developmental perspective. This considers how previous developmental tasks may

have been disrupted by any trauma, and how trauma during this time may additionally disrupt the successful completion of the current developmental tasks.

For example Moran, Vuchinich and Hall (2004) draw on developmental psychopathology approaches to explain their findings regarding the impact of abuse, suggesting a ripple effect on future development. They also widen the immediate effect of abuse, making the suggestion that the ensuing deficits in cognitive, social, emotional and behavioural domains lead to other problematic outcomes.

Research into the impact of abuse during adolescence has focused on these domains. The research is considerably complicated however by the challenges faced by any child during this stage of life. Developmental theories highlight the potential for predisposed vulnerabilities created at this age by the poor resolution of previously salient tasks.

Difficulties at this stage, whether internalising or externalising, may carry with them increased risks for their future developmental trajectory. An adolescent may establish patterns of behaviour and personality characteristics that follow them into young adulthood as they attempt to negotiate the salient tasks of successful transitions. These include the transition to secondary schooling, academic achievement, skill acquisition, psychological autonomy, forming friendships and relationships, and deriving a coherent sense of personal identity (Cicchetti & Rogosch, 2002).

This sense of personal identity has also been commented on by Drayton, Birchwood and Trower's (1998) paper, which notes the role of disturbed family relationships that may

challenge the development of a secure sense of self. They point to two consequences of this trauma in childhood, firstly that a fragile sense of self may develop, which would lead to interpersonal difficulties and negative self-evaluation. Secondly they note the immature and inadequate defence mechanisms used to cope with their difficulties. Although these defences may pass unnoticed in a younger child, their continued use may explain some of the common difficulties seen in this group of abused children at adolescence.

SECTION 3 – EFFECTS IN ADULTHOOD

Section 3.1 - Evidence of Effects in Adulthood

It is clear from the evidence presented above that the impact of physical abuse on children and adolescents is far reaching. Unfortunately it seems likely that these difficulties do not cease with the transition to adulthood. Although this stage of life may bring with it increased independence, and in many cases the opportunity to escape abusive experiences, this life stage requires the negotiation of its own salient tasks. As Lubitt et al., comments “the full impact of abuse may not be experienced until the child reaches adulthood and engages in adult relationships and responsibilities” (2003)

In order to present the data regarding the impact of abuse, this review will consider data regarding more neurotic difficulties, before considering the impact on personality, and the more severe spectrum of mental health difficulties in psychosis.

Prevalence of Abuse histories in Adults.

Research into the potential impact of abusive experiences has flourished with the recognition of the increased prevalence of abuse histories within certain psychological difficulties. Data regarding the prevalence and nature of abusive experience has been created using widespread surveys of the general population, in addition to establishing the prevalence of these types of experiences in adults who are later in contact with services due to mental health difficulties.

Prevalence of abuse in the general population is variably reported at around 25% although this depends somewhat on the definition used. However, the prevalence rates within a psychiatric population are considerably higher, Friedman et al. 2002 found an incidence rate between 16 and 40 % in psychiatric outpatients. The difficulties in establishing rates of prevalence will be discussed in a later section regarding research challenges in this area.

Neurotic Difficulties

A number of authors have focused on the potential development of post traumatic stress disorder as a result of childhood abuse experiences (Kiser et al., 1991; Lindberg & Distad, 1985; Rodriguez et al., 1997) and it is noted that the rates of PTSD in adult survivors is higher than in child or adolescent survivors. This has been interpreted in support of the notion that abuse may have some impact that does not emerge until adulthood.

In addition to post traumatic stress, there is increasing evidence for the increased prevalence of childhood abuse histories in anxiety difficulties and panic attacks. This was noted in Fergusson et al.'s (1996) research, and highlighted in the review by Trickett and McBride Chang (1995). Van der Kolk and Fisher's (1994) model also suggests a role of the increased difficulties in regulating affective arousal for individuals who have experienced physical abuse, and the potential role of traumatic stress reactions heightening the individual's sense of danger about the world or others.

Empirical studies show a history of childhood physical abuse has been associated with depressive disorders (Lizardi et al., 1995; Wexler et al., 1997), and is thought to potentially link to the internalised negative messages from the abuser. As noted in adolescence increased rates of substance misuse are common (Greenfield et al., 2002; Miller et al., 1993; Rice et al., 2001; Rodgers et al., 2004), and potentially used as a coping mechanism for post trauma symptoms. In addition social problems such as marital breakdown (Friedman et al., 2002), interpersonal difficulties and increased aggression (Briere & Runtz, 1990; Lopez & Heffer, 1998) has been shown to continue from childhood into adulthood. Similarly poor health behaviour is noted in this post abuse population including poor management of chronic pain (Green at al, 1999), and more risky health behaviours such as poor exercise, smoking, and sexually risky behaviour (Rodgers et al., 2004).

Psychotic Difficulties

When considering psychological difficulties categorised as more severe and enduring mental illness, there has been a similar recognition of the increased prevalence of childhood abuse histories in this particular group of adults. There have been a variety of rates found between studies from 18% by Ystgaard et al. (2004) up to the 40% reported by Friedman et al. (2002). This variance indicates the difficulty in establishing abuse rates in any population, but may also be indicative of the failure of clinicians to clarify abuse histories. Greenfield et al. (2002) noted 20 out of 38 patients admitted for early episode psychosis reported a history of childhood abuse when asked, and an earlier study by Briere and Zaichi (1989) found the records of just 6% of a sample of women

attending a psychiatric emergency room noted abuse, however when asked 70% of these women reported childhood abuse.

Research with this population of more severe mental health difficulties such as psychosis has also examined the potential link between the severity of the difficulties experienced and the presence of childhood abuse. Read 1998 used a medical records review to examine the relationship between the experience of physical and sexual childhood abuse and markers of more severe symptoms. Results indicated an earlier age at first admission to psychiatric hospital, an increased in admissions to hospital and increased length of individual admissions, higher rates of suicidal ideation and attempts and increased likelihood of admission before the age of 18 years within groups of patients who had reported childhood abuse.

Within psychosis a number of authors conducted research to investigate the potential role of childhood physical and sexual abuse (Livingston et al., 1987; Read, 1999; Shearer et al., 1990), emotional abuse and neglect (Fosse & Holen, 2002) adult assault and posttraumatic stress disorder (Mueser et al., 1998) and early rearing environment (Niemi et al., 2003).

Attempting to consider the impact of specific abuse types and psychotic symptoms Read, Agar, Argyle and Aderhold (2003) studied hallucinations, delusions and thought disorder in distinct categories, and found significant differences between the type of abuse experience and the hallucinations that were reported. They noted a significant difference in the hallucinations of the abused and non-abused group, and a similar

distinction between the types of abuse reported. Somewhat unexpectedly the sexuality of the symptom content was 7 times more likely for both physical and sexual abuse than for those who had not experienced abuse, but there was no observed differences in terms of delusions or thought disorder. The authors suggest a number of possible reasons for the link in symptoms to abuse, including the possibility that flashbacks are misattributed, or that the attribution of symptoms to present difficulties prevents the painful recall of the past.

One of the main difficulties within this research has been in separating the impact of these different forms of abuse, and this will be commented on further in a subsequent section reviewing the challenges inherent to this area of research.

Section 3.2 Theoretical Models of Difficulties

Developmental Psychopathology

In addition to interest in the prevalence and increased frequency of abuse histories, there has been renewed interest in the characteristics of survivors of childhood abuse. Developmental psychopathology models note that children may be increasingly vulnerable to traumatic experiences as “their vision of the world as safe or dangerous, helpful or unhelpful, predictable or unpredictable, controllable or out of control, is in flux. Images of the self as effective or ineffective, brave or cowardly, good or shameful are also under revision” (Lubitt et al., 2003)

An exploratory study by Varia et al. (1996) noted that adults with experience of abuse in childhood had poorer personality adjustment and less healthy social relationships. Steel

et al. (2004) showed evidence that in general emotion focussed coping is associated with long-term negative sequelae, and it seems likely that children are more likely to rely on such strategies when they are unable to make use of social support and problem solving techniques due to family disruption and developmental level.

Leitenberg et al. (2004) provide supporting evidence for the continuation of these coping styles into adulthood. In their large sample of undergraduate females there was an increased use of disengagement coping strategies (i.e. wishful thinking, problem avoidance, social withdrawal and self criticism) in subjects with abuse histories.

In a similar manner attributional style and adjustment is noted by Valle and Silovsky's (2002) study to relate to abuse experiences. They provide some evidence that childhood physical abuse recipients internalise their parents negative beliefs about them, are more likely to have an external locus of control, view the world as more unpredictable and threatening, all of which are positively associated with depression, anxiety, hopelessness, externalising and self esteem problems.

Links between psychosis and childhood abuse

Asides from the increased prevalence of abusive experiences in this population, and the link to increased severity of symptoms, in recent years authors have begun to consider the link between the experience of childhood abuse, and how this may contribute to the specific symptoms which are present.

Given the increase in psychological attention to cognitively driven models it is not surprising to note an increased interest in delusional belief systems, both in terms of how they are developed and how they are maintained. Read et al.'s (2003) empirical paper cites the suggestion by Briere (2002) that delusions could develop from attempts to make sense of abuse flashbacks. Similarly research that investigated delusions primarily have pointed to the early experience of abuse. For example, Birchwood (2003) relates trauma history to developmental anomalies in the schema governing the processing of self and social information. His model of auditory hallucinations suggests that childhood experience can lead to schemas, which fuel voices and paranoia.

This model is supported by evidence that negative schemas provide content to psychotic attributions (Blowins & Shugar, 1998; Fowler et al., 1998) and by the suggestion that specific abuse experiences are seen in delusional beliefs, such as Beck and Van der Kolk's finding of increases sexual delusions in incest survivors (1987).

SECTION 4: THEORETICAL LINKS BETWEEN PHYSICAL ABUSE AND PSYCHOSIS.

The review will go on to consider the theoretical models of how abuse has such far-reaching effects. This section will focus on the meaning taken from the experience of abuse and the contribution this makes to the cognitive models. The review will then take the specific instance of delusional beliefs to consider the role of childhood physical abuse.

Section 4.1 - The Role of Meaning in Cognitive Models

In 1993 Williams commented that the outcome of abuse experience varies “depending on how events are perceived, appraised and processed”. Steel et al. (2004) support this with evidence that in addition to abuse characteristics moderating outcome, coping strategies of confrontative coping, accepting responsibility, internalisation, escape and avoidance coping strategies are associated with more negative outcome. In contrast seeking social support and problem solving coping acted as a buffer to distress.

Similarly Valle and Silovsky’s (2002) study shows evidence that the established role of cognitions moderating the effect of stress outside the field of abuse. Outcome could therefore vary according to internal / external or specific / global attributions and whether the events were perceived as controllable or not.

Clearly when considering physical abuse, within the care giving relationship, the impact and meaning of the abuse is likely to be tied to the relationship with the care giver. Carlson et al. (1997) notes that children who have experienced physical abuse internalise

their parents' negative beliefs about them. Cognitive models link these types of early experiences and core beliefs to adult cognitive style and expression of symptoms.

Indeed there is evidence for the continuing impact of childhood physical abuse in attributional style and appraisal as noted by Dodge et al. (1997). They found that children who had experienced physical abuse paid less attention to relevant cues, had an increased prevalence of a hostile attributional bias, and were more likely to generate aggressive responses in response to ambiguous situations or information.

These findings are added to by the information regarding the impact of other forms of violence, namely corporal punishment. In this field there is long standing evidence (as reviewed by Gershoff 2002) that the cognitive style, behavioural and emotional responses are modified by their experience, with long reaching effects into adulthood, to the extent that it can predict individual's violent responses in their own care giving experiences when they mature and become parents themselves.

Section 4.2 – The application of Cognitive Models to Psychosis

With regard to more serious psychopathology such as psychosis the early life experience of these patients has often been considered in research efforts, not least because of the high levels of abusive experiences in childhood recorded in this population.

In considering the influence of abuse on these more serious psychopathologies, the review will consider the historical explanations of psychotic symptoms, focusing on

cognitive models. Finally the review will consider how the various effects of childhood physical abuse may contribute to the formation and maintenance of delusional beliefs.

Stress / Vulnerability Models

As can be seen in the review so far, the experience of childhood physical abuse is likely to have an impact on a number of developmental tasks, which may create vulnerabilities to later mental health difficulties. Within the field of psychosis, the stress-vulnerability model has been increasingly prevalent in the explanation of the development of these difficulties, and childhood abuse would seem to be one of many factors which may create both vulnerabilities in terms of cognitive models, or stress potentially in terms of anomalous experiences resulting from post trauma symptoms. A number of authors have considered this link, and this review will take a historical approach in conveying the developing models of psychosis, with a particular focus on delusional beliefs, and how childhood physical abuse may contribute.

Over the past century the dominant focus of theoretical thinking regarding psychosis and delusions concentrated on the biological determined vulnerability. Early in the century the potential information in delusional content was disregarded by writers who considered that the ‘meaningless’ nature of delusions was part of their diagnostic characterisation (Jasper, 1913)

The Cognitive Model

The earliest cognitive models highlight the role of early experience in the creation of the core beliefs about the world, which drive people to make sense of their experiences in

certain ways, frequently leading to psychological difficulties. As early as 1952 Beck wrote regarding the application of cognitive models to work with individuals with psychosis, suggesting the application of normal cognitive techniques to challenge beliefs previously considered abnormal and therefore non susceptible to psychological therapy.

Despite this early application of cognitive ideas, there was a gap in the pursuit of psychological work in this area through the 60's and 70's, until renewed interests by authors such as Birchwood, Chadwick, and Trower (1996) who have encouraged the application of Cognitive theory (Beck, 1979) to psychotic phenomenon.

The simple understanding of symptoms using ABC analysis has focused attention on the symptom as a trigger to cognitive processes. This is supported by research work noting patient's attempts to gain understanding and establish meaning to their experience (Chadwick & Birchwood, 1994). These findings led to further research into differences in cognitive processes of individuals with psychosis, as it highlighted the role of beliefs regarding power and authority in mediating differing reaction such as fear, acceptance and compliance with voices.

This work is particularly pertinent to the investigation of the role of abuse due to the links between experience of trauma and the development of negative schema, attributional style, appraisals for meaning, probabilistic reasoning and interpersonal relationships. Morrison's theoretical paper has noted the potential for schema not only to predict a predisposition to auditory and visual hallucination (Morrison et al., 2000), and Birchwood's (2003) research noting that trauma history influence the development of

schema themselves, which would then govern the processing of self and social information.

Similarly Birchwood et al.'s (2000) theoretical model of auditory hallucinations suggests childhood experience can lead to development of schemas involving social humiliation and subordination, which in turn fuels both the experience of voices and paranoia, and the manner in which an individual deals with them.

Section 4.3 - Cognitive Models of Delusions

The Search for Meaning

This increased interest in psychological work with psychosis was at least partly fuelled by the recognition that psychotic thinking processes lie on a continuum with normal ones. In the 1970's Maher outlined his model regarding the formation of delusional beliefs suggesting that the thinking in itself was not in itself aberrant, but best considered as theories attempting to make sense of the anomalous experiences, which the individuals are sensing. This creates what Maher refers to as an automatic 'search mode' to explain the discrepancy. When an explanation is found it creates a sense of relief and reassurance, which is naturally reinforcing. Since the anomalous experiences are not observable by others, the beliefs are judged delusional. Maher further explains the maintenance of the beliefs by a natural tendency to maintain our beliefs despite disconfirmatory evidence due to attributional biases in normal cognitive processes.

Attributions / Self representations

This work is built upon by later authors who note the role of attributions, and who expand the picture to include the role of early experience in creating a vulnerability to thinking styles. This has been seen particularly in the exploration of persecutory delusions. Bentall and colleagues (2001) present an integrative model based on the attribution – self-representation cycle. In this review attention is brought to a body of research that confirms that certain environmental conditions are associated with paranoid thinking with empirical evidence such as experiences of victimization and powerlessness (Mirowsky & Ross, 1983), intrusive events (Harris, 1987) and discriminating, humiliating and threatening experiences (Fuchs, 1999). Bentall and colleagues further suggest that the attributional bias's noted in individuals with persecutory delusions may serve as a defence against an otherwise fragile ego (2001). This externalisation of the causal attributions are thought to be evoked for negative events which might otherwise increase the awareness of the underlying negative self evaluations, and therefore maintain self esteem.

Externalisation

The increasing empirical research into this possibility does debate the increased externalisation of those with delusions, with Lyon et al. (1994) and Sharp et al. (1997) suggesting there is an externalising bias, but Kinderman and Bentall (1997) suggesting that the externalising bias may not in fact be self serving. A review by Freeman and Garety proposes a multi dimensional model for persecutory delusions (Freeman et al., 2002). In this model they incorporate the notion of attributional biases, but suggest that

cognitive biases must combine with anomalous experiences, emotional beliefs about the world and a search for meaning which leads to the selection of an explanation.

This model has the stress vulnerability model to psychosis as its basis, but formulates the delusion as beginning with a trigger of some form that creates confusion; sleep disruption and an increase in anomalous experiences. As in normal cognitive processes the individual searches for meaning for their experience, and in this they are likely to draw upon their pre-existing beliefs about the self, others and the world. Freeman et al. suggest this is mediated by factors such as pre-existing beliefs regarding madness and illness, social isolation and the level of flexibility in their beliefs, which may also serve as prognostic factors for treatment outcome. The maintenance of delusions result from the inherent reinforcement of the relief that comes with the explanation chosen, which is then confirmed by pre-existing ideas and beliefs and attentional bias. In addition they note the likelihood of the person's interactions confirming their beliefs as they elicit hostility, or rejection from those around them.

The role of Abuse and Trauma

In this model it appears that the pre-existing difficulties found in individuals who have experienced childhood abuse would have a clear role. Individuals are noted to have increased interpersonal difficulties, and in physical abuse would seem likely to have developed a number of beliefs regarding the potential threat and danger of others and the world. In addition the stress vulnerability model would indicate the role of abusive early environment in creating vulnerability, and the potential posttraumatic stress responses emerging in late adolescence and early adulthood.

In recent years, Morrison (in press) has suggested a more overtly traumagenic model of psychosis focusing on the theories regarding post traumatic stress disorder and the potential similarities between these difficulties and more psychotic symptoms.

Morrison reviews in detail the relationship between trauma and abuse, and considers the possibility not only that psychosis can cause a posttraumatic stress reaction but also that trauma itself can directly cause psychosis.

In this work Morrison draws on the literature noting biased attributional styles and interpretations of ambiguous events and goes further to link how these could lead to delusional beliefs. He notes the suggestion by Maher that delusions may develop from a rational search for explanation of anomalous events and links this to the potential for an individual with a hostile attributional bias to create paranoid interpretations of events.

Further to Morrison's view of the links between psychosis and trauma, Briere (2002) suggested that delusions could be an attempt to make sense of flashbacks of traumatic abusive experiences, which are not recognised by the individual. Recent models of posttraumatic stress disorder suggest a specifically different memory process for traumatic memories (Brewin et al., 1996) that increases the likelihood of intrusive flashbacks. In keeping with these ideas the suggestion of the possibility of two pathways to the positive symptoms of schizophrenia, an endogenous one, and a second more primarily driven by childhood psychosocial trauma has been made (Ross et al., 1994).

With this idea in mind it is useful to note Van der Kolk and Fislser's (1994) work regarding the areas of disturbance following interpersonal trauma. These are thought to be alterations in regulating affective arousal; dissociation and amnesia; somatisation; chronic characterological changes in areas of self perception; perception of others and relationship with the perpetrator and alterations in systems of meaning.

Clearly then there are a number of different possibilities suggested that link childhood physical abuse and the later development of psychotic symptoms and delusional beliefs. However, there are a number of challenges to conducting research in this area, which impact on the explanations presented so far. The review will therefore go on to consider the challenges inherent in attempting to trace the impact of childhood abuse, before critically evaluating the models presented thus far.

SECTION 5: DIFFICULTY WITH ABUSE AND PSYCHOSIS RESEARCH

In reviewing the literature regarding the links between childhood physical abuse and delusions there are a number of areas that are open to criticism. The review will consider difficulties in conducting research in this area, before expanding on the difficulties in the models presented so far.

Methodological Difficulties

Recruitment and Selection

With regard to methodological difficulties, investigating the impact of abuse is complicated by a number of factors. In cases where abuse is reported or discovered when it is occurring, it is more straightforward to establish the difficulties the child is experiencing in comparison to their non-abused peer group. Standard psychometric approaches have been used to this end, in addition to use of third party informant and observational data to inform researchers and clinicians of the more immediate impact of childhood abuse.

However, clearly these approaches have a fundamental flaw as they can investigate only those children who have clearly documented experiences of abuse. This presents two immediate difficulties, firstly in the wide variety of the abuse experience and secondly that it fails to investigate, and may wrongly assign to a control group, children who are being abused but are not able to report it.

Impact of Disclosure

In addition, the disclosure of abuse can be considered a traumatic event in itself, given the likely ramifications for the child and their family. This research therefore faces a challenge in clearly distinguishing the immediate impact of having disclosed abuse and moving forward as compared to considering the impact of abuse at the time in which it is occurring.

Impact across the lifespan

The impact of abuse across the lifespan faces similar challenges. In adolescence, the data is similarly blurred by the impact of disclosure, and the difficulty in establishing a control group for comparison purposes. In addition it is also noted that some of the impact of childhood abuse does not appear to emerge until later in life, suggesting a complex relationship rather than a straightforward model based on posttraumatic stress symptoms. In adolescence however, the research can use prospective methodology, following up children who have documented experiences of abuse earlier in life and considering their difficulties at this time. Challenges to the use of retrospective methodology are also more easily defended given the shorter time span between the experiences and the measurement of difficulties. Self-report measures of difficulties are also more easily administered by this time.

There are a number of methodological issues related to the investigation of the impact of abuse in childhood on the adult later in life. Research in adulthood is advantaged in its ability to establish comparison groups, given the separation from events, which are no longer occurring. However, true comparisons are hindered by the variance in severity,

frequency and duration of abuse, both when considering a single child's experience in comparison to other children, and when considering a single child's experience across their own upbringing. This is frequently overlooked in the research, measuring abuse experience with simple yes / no questions, and often collapsing abuse categories into 'abused' or 'not abused' rather than including the frequency or severity of abuse in the analysis.

In considering the medium to longer-term impact of abusive experiences, researchers are largely forced to rely on retrospective accounts of abuse, which are difficult to corroborate. This data has been called into question over the validity and reliability of the memories and reports of adults on a number of grounds.

Clearly depending on the age at onset of the abuse, an adult's memory of their experiences may be more or less reliable, and may be contributed to by family stories. The ability of a respondent to accurately report on frequency and duration of abuse may be complicated by the nature of traumatic memory encoding, and the ongoing complication of the care giving relationship in which abuse frequently occurs. In cases of physical abuse in particular there is the added complication of the impact of physical injuries, which may impact the child's ability to remember (i.e. head injuries). Finally it is possible that for some children who are forced to hide their injuries that they may learn complicated fabricated excuses that could cloud the true experience.

Similarly in cases of self-report, adults are considerably impacted by their perceptions of which experiences they would consider abusive, which varies according to factors such

as cultural and societal attitudes to corporal punishments, and their perception of how 'deserved' their punishment or abuse was.

Minimisation of the role of abuse

In addition there is an increased recognition of the failure of clinicians to consistently inquire about abusive experiences, limiting the accuracy of prevalence rates, but also suggesting that research which utilises patient records rather than direct contact may be failing to access a large population of abused individuals.

In addition to methodological difficulties in the design of research work, the evidence presented has been criticised on both sides for either emphasising the role of abuse, or for de-emphasising it.

In 1997 Read reviewed the links between childhood experiences of abuse and later psychosis and noted a number of ways in which this relationship has been minimised. Commonly within the research psychotic individuals are excluded from the data, presumably over questions regarding the validity or reliability of their self-report data. In addition much research relies on reviewing medical records for evidence of abuse, rather than interviewing participants. This appears likely to reduce the number of individuals who are accurately identified as having been abused.

Read also notes a common system whereby the discovery of abuse in childhood may actually lead to a re-classification of the diagnosis which an individual receives, given the rise in clinical recognition of the longer term effects of abuse. On a clinical level this

appears to be a positive sign of progress in recognising the longer term impact and differing intervention needs of this sub section of psychiatric patient, but Read notes it also may serve to reduce the apparent data noting the co-occurrence of psychotic symptoms and childhood abuse histories.

The overlap between posttraumatic stress and psychosis

In addition research on psychosis is complicated by the potential overlap of psychotic symptoms with posttraumatic stress symptoms. This is particularly notable when investigating individual symptoms such as voices, where it is likely to be difficult to distinguish what is considered a hallucination, and which may be a post traumatic flash back. In the same way beliefs considered delusional may be based on the reality of childhood experiences, giving a very real basis for unusual attributions about for example the level of danger they feel, or the attributions of others.

Limitations of Qualitative Research

However, criticisms are also levied at the research from those who suggest the reliance on self-report, qualitative methodology and small n studies, create a circular research process where researchers viewpoints eclipse the data presented. Rind et al.'s paper (1998) however was controversial in its debate over the true impact of childhood abuse when they highlighted the differing outcomes of survivors. In pointing to the considerable resilience of many individuals the sensitivity of this topic area was apparent in the debate that ensued within the journal. However, the resilience of individuals does support a more complex formulation of the origins of psychotic symptoms, one that would require a more multi-modal approach.

Multiple Abuse Experiences

Finally a clear difficulty in this field of research is the limited recognition of the multiple abuses experienced by most participants. Although some authors provide evidence for similar outcomes between physical and sexual abuse (Margo & McLees, 1991; Mullen et al., 1996; Wind & Silvern, 1992) it is also suggested that there are clear differences in the outcome of these types of abuse, challenging the validity of research that subsumes them in to one group (Cohen et al., 1996; Luster & Small, 1997).

In addition there has been a particular tendency in the research to discuss findings regarding abuse in general, when the research has in fact focused on a particular type of abuse. Traditionally sexual abuse has been considered to be the most severe type of abuse where more than one is present, a suggestion that has yet to be established from the population. In the research into physical abuse, there remains the complication of self-report, where society does not give clear messages regarding the acceptability of physical punishment, and many participants in research may not consider their experiences to be unusual or unacceptable, despite the injuries that they received.

CONCLUSION

In reviewing the literature on the impact of childhood physical abuse, and its potential links to psychotic symptoms it is clear that this is a field still very much in development, with most of the pertinent research taking place in the last two decades. This represents an increased recognition both of the prevalence of abuse, and the potential role it has in affecting adult psychological difficulties. However it is additionally clear that the theoretical links are still contentious, influenced by early research, which may have numerous flaws and requiring further investigation. It has been particularly difficult to establish a literature base that clearly delineates different types of abuse and their effects.

Although this may to some extent relate to the frequent occurrence of multiple forms of abuse, the research is at present tainted by the failure to consider how multiple abuses and early childhood adversity may combine. Findings suggesting the role of childhood physical abuse, where there was additionally sexual abuse, family violence, neglect and poverty is simplifying the potential links.

What is clear from the research however is the high prevalence of abuse in individuals with psychotic symptoms. The increased application of cognitive theory to psychosis has allowed a productive development of theoretical links between early experience and the development of cognitive processes that contribute to psychosis. From reviewing the research it seems immediately apparent that delusional belief systems, fuelled by anomalous experiences are a complex system influenced by a number of differing

attributes, and best explained by a multi modal model which is able to take into account the wide variety of contributing factors.

Fruitful research breaking down the wider concepts of 'psychosis' and 'abuse' into individual symptoms and maltreatment type suggest the utility of a continued research effort in this area. This would potentially allow for more useful clinical information regarding the impact of abuse and how it may best be addressed.

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Part Two

Childhood Physical Abuse and Delusional Content

Empirical Paper

Abstract

Objectives: The experience of physical abuse in childhood has been linked to psychological difficulties in adulthood including psychotic illness. This study aimed to explore how the experience of childhood physical abuse impacts on the content of delusions formed in adulthood. A further aim was to investigate the ability of expert raters to reliably reconstruct individual cases using information regarding abuse history.

Method: 15 participants with a history of delusional beliefs completed the Young's Schema Questionnaire (YSQ) and Bernstein's Childhood Trauma Questionnaire (CTQ). They were subsequently interviewed regarding the content of their delusions using a standard psychiatric interview. Thematic analysis of the content of delusions was conducted so as to systematically examine putative relationships with abuse and schema results. In addition, an independent expert panel was asked to distinguish delusional content and schemas according to the nature of abuse and also to attempt to reconstruct individual cases from vignette material.

Results: The thematic analysis revealed five major themes in the delusional beliefs, threat from others, badness of self, religion / spirituality, control and special status / talents. Interestingly, these themes were not reflected in the content of schemas. The panels were not able to reliably distinguish delusional beliefs or schemas on the basis of the abuse experienced, neither were they able to reconstruct individual cases.

Conclusions: Neither rating of vignettes by experts nor thematic analysis led to successful links between the nature of abuse and delusional content. Limitations included the small population, the differing meaning of abuse for individuals and the absence of information about adult trauma.

Introduction

Considered to be one of the foremost signs of psychopathology, delusional thinking attracted much attention over the course of the past century. Theories regarding the origins of delusions have ranged from the psychoanalytic Freudian ideas of conflicted desires (1939), personality traits (Cameron, 1959), to the more recent developments in cognitive thinking that suggest cognitive or attributional bias (Bentall et al., 2001; Frith, 1992; Garety & Freeman, 1999). Research and clinical work with this population however has traditionally been scarce, perhaps due to the persisting belief that delusional content was meaningless (Jasper, 1913) and that the psychotic population was not suitable for psychological intervention.

As cognitive models have been more widely applied, thinking regarding how delusional beliefs are formed and maintained has changed. There has been increased evidence for the role of normative thinking processes, with Maher's work in the 1970's and 1980's suggesting delusional beliefs are not aberrant thinking, but rather that they are theories which an individual creates in order to make sense of the anomalous experiences common to psychosis. In 1990, Roberts suggested a more integrated framework for understanding how delusions are formed, and how they crystallise into the chronic, elaborate and stable belief systems that are observed. He proposed a stage model whereby predisposing and precipitating factors led to a prodromal stage of unusual experiences to which meaning is attributed. This allows the formation of simple delusions, which over time may be elaborated. This model draws on a number of suggestions made over the years, including Bleuler's original suggested explanation of a

breakdown in the association between thinking and feelings, weakening reasoning and enhancing the effect of emotional arousal (1950).

More integrative models have gathered support and from the late 1980s research work has increased, testing the theoretical explanations of the formation of delusion and attempting to build a more comprehensive model of delusion formation. The cognitive models developed by Bentall et al. (2001) have offered a central role of attributional style in the creation of persecutory delusions, in order to defend against threats to a fragile self-concept. Freeman et al. (2002) have challenged the defensive model, considering a multi modal approach that integrates attributional style, cognitive biases and an intrinsic drive to search for meaning. These complex models are helpful in considering not only the development of delusional beliefs systems, but also in explaining how they are maintained.

Clinical work has also added greatly to the understanding of delusions. As early as 1952 Beck wrote of the potential for clinical work to make sense of and modify delusional beliefs. This suggestion of modifying delusional beliefs was furthered by Watts et al. (1973) who found they were able to modify beliefs by avoiding a direct confrontational approach in discussing the beliefs, and instead discussing alternatives and the evidence that underlies the belief. In challenging beliefs, the meaning the individual makes of the delusion is placed centre stage. In addition to the formation and maintenance of delusions then, their content has been given increasing attention.

'Making sense' of experience has been recognised as a driving force in the models of delusion formation. Studies have drawn upon how an individual plays an active role in processing their experiences. Formulations of delusions proposed by Birchwood and Chadwick (1996) and Garety (2000) highlight the role of early experience in establishing vulnerabilities. This emphasises the central beliefs an individual holds which inform how they view themselves, others and the world. Early experience is thought to give a predisposing vulnerability to certain thinking styles and may also play a role in determining the content of the delusion formed.

Researchers have begun to consider the influence of atypical early experience, with a particular focus on the potential for abusive experiences to influence the development of psychosis (Briere, 2000; Morrison, in press; Read et al., 2003). Ross et al. (1994) suggests a number of pathways to schizophrenia and the symptoms involved, one of which may be the early experience of trauma such as childhood abuse. This is supported by Briere (2002) who suggests there is a potential for posttraumatic flashbacks to be misunderstood. This would lead to an interpretation that these anomalous experiences are due to external persecution or threat, rather than understanding them as related to the trauma experienced earlier in life. The established emergence of delayed PTSD in adult life following abuse in childhood may provide an explanation for the emergence of psychotic symptoms at this stage of life (Lubitt et al., 2003). In a similar vein Morrison (in press) links psychosis and trauma in a number of ways, one of which postulates a specific link between early experience and psychotic symptoms. Read (1997) also writes that the prevalence of abuse histories within a psychotic population is

also suggestive of a role of trauma in the genesis of psychosis. Read has published a number of studies which establish a link between childhood abuse and an increased severity of psychopathology in later life (Read, 1997; Read, 1998; Read et al., 2003). In addition he has further explored the potential relationship between abuse and separate symptoms of psychosis (such as auditory hallucinations and thought disorder – Read et al., 2002). In establishing research regarding these links Read highlights a number of factors that can disguise the impact of abuse. One example is the exclusion of psychotic individuals from the data, which Read suggests may be over questions regarding the validity or reliability of their self-report data. In addition much research has relied on reviewing medical records for evidence of abuse, rather than interviewing participants, which may yield more accurate information. Despite the increasingly recognition for the prevalence of abuse within psychotic populations, establishing a link to delusional content has remained a challenge.

The content of delusions is divided by the DSM-IV into erotomanic, grandiose, jealous, persecutory, somatic and mixed types. However a number of authors have challenged these content categories of delusions, Freeman and Garety (2000) questioning the content of persecutory delusions and Motjabi and Nicholson (1995) finding the ability of clinicians to distinguish the ‘bizarre’ category to be extremely low. Rhodes, Jakes and Robinson (in press) have suggested that there may be as many as 34 themes to delusional content, and recommend increased research into the complex interaction between delusional themes. In terms of content, persecutory delusions appear the most studied and research into content is often simplified to content categories of persecution

or non-persecution (i.e. Sharp et al. 1997). Persecutory delusions have also been examined regarding issues of severity of harm and level of distress. Startup and colleagues (2003) investigated the content of persecutory delusions and linked anomalous experience as a determining factor in the severity and harm expected and the level of distress seen. The meaning of delusional content has been increasingly recognised on individual levels. The formulations of delusions described by Moorhead and Turkington (2001) in their single case study report suggests the central role of early experience in the content of the beliefs developed. Just how such early experience comes to have its effects has led to the conceptualisation and measurement of beliefs and schemas thought to influence later psychopathology (Young, 1999; Young et al., 2003). For example Morrison et al. (2000) have noted the predisposition to auditory and visual hallucinations is higher with those individuals who report positive beliefs about these types of experiences, and this further predisposes the strategies used to control these symptoms. The role of schemas and predisposing cognitive processes has been given more attention in the formation and maintenance of persecutory delusions, but it has not yet been specifically linked to other delusional content despite the increased acknowledgment of meaning and interpretation in both early experiences and the formation of delusional beliefs. Case studies such as that published by Moorhead and Turkington provide rich information and highlight areas for future research. It can be difficult however to generalise their findings.

Within psychology alternative methodologies have developed to capture richer idiographic data and access complex interactions. Qualitative methodology in a variety

of forms has increased in popularity in recognition of its capacity for understanding psychopathology and it has been used to consider psychotic symptoms. Since research on the impact of abuse notes a variety of possible outcomes from these experiences, it is clear that there is an important role of meaning and interpretation on the part of those who experience it. It is possible that through utilising qualitative methodology it will be possible to establish some ideas regarding the influence of childhood physical abuse on the content of delusional beliefs developed in adulthood.

Studies have frequently made use of clinical cases in the form of vignettes to test both the ability of clinicians to reliably distinguish the content (Lovedahl & Frillis, 1996; Rock & Preston, 2001; Schutzwohl et al., 2003; Startup et al., 2003), and the validity of the content categories themselves (Motjabi & Nicholson, 1995; Spitzer et al., 1993; Willemse et al., 2003). Clinical vignettes provide the researcher with a way of presenting richer individual data regarding participants in a way that allows for comparisons to be made. This can be done by creating vignettes that differ in some small aspects to test the clinical approach being used; alternatively real clinical vignettes can be used to test the reliability and validity of the links clinicians are making.

Aims

This study aims to explore the potential links between the experience of childhood physical abuse and the schemas and delusions experienced as adults. The study will address the following questions:

1. For those individuals who have experienced childhood physical abuse what themes emerge in the content of their delusions, and how might these relate to their experiences?
2. Are there links between the schemas of individuals who have experienced physical abuse in childhood and the content of their delusions in adulthood?
3. Can expert raters reconstruct cases accurately using clinical vignettes providing standardised information on early abusive experiences, schema and delusional content?

Method

Overview

This study aims to explore the links between the experience of childhood physical abuse and the schemas and delusions experienced as adults. 15 interviews were conducted with individuals who had experienced physical abuse in childhood and who had developed delusional beliefs later in life. A thematic analysis was then used to explore the themes emerging at interview.

In order to address the additional research question regarding the ability of clinical panels to accurately formulate the connections between abuse experience and delusional themes, an independent panel was recruited to complete a task. For this a further 4 interviews were conducted with individuals who had not experienced physical abuse. The panel was asked to complete a number of tasks separating vignettes describing participants who had experienced physical abuse, from those who had not.

Participants

15 participants who had experienced physical abuse were recruited through the community mental health teams and inpatient services providing psychiatric care to a large London borough. A further 4 participants were recruited who had experienced emotional abuse from the same sources.

Inclusion criteria

Participants were aged between 18 and 65 and were excluded if they were unable to speak English. Participants were additionally excluded if their psychosis appeared to be

primarily driven by drug or alcohol use, or if they were reported to have significant learning difficulties that would prevent them being able to complete interviews or questionnaires. Participants were also excluded if their care team did not feel they were well enough to either give consent or complete the interview and questionnaire process. Participants were given an information sheet and asked to sign a consent form (please see appendix 1 and 2). In addition their care co-ordinator was informed that they were taking part (see appendix 3).

Description of participants

Physical Abuse Participants

15 participants were recruited who had experiences of physical abuse (scoring over 10 on the CTQ). Participants were aged between 25 and 60 with a mean age of 39.66 (Std. Dev. 9.18). 9 participants were male and 7 female. At the time of interviewing 4 participants were inpatients and the remaining 11 were outpatients. The majority of the participants had a history of psychosis for more than 10 years (9 participants), 4 had experiences of psychosis between 5 and 10 years, and just two participants had experiences of psychosis for less than five years. In terms of ethnic origin, 5 participants described themselves as White-British, 2 as White-Irish, 5 as Afro-Caribbean, 2 as Nigerian and one participant described himself as British (other).

Emotional Abuse Participants

4 participants were recruited who had experiences of emotional abuse but did not reach the cut off scores for physical abuse. These four participants were aged 23, 32, 37 and 42. All four participants were female and living in the community. All four participants had a history of psychosis of between five and ten years standing. The participants described themselves as White British (2) and Afro-Caribbean (2).

Ethical considerations

Barnet, Enfield and Haringey NHS Trust, granted ethical approval. Liaison with multi-disciplinary staff was conducted prior to the interview to check on the current mental state of participants, and participants were approached in the first instance by a mental health professional with whom they were familiar (their Key-worker, Community Psychiatric Nurse or Psychiatrist). In addition, follow up at the Psychological Therapies Service was made available to participants should they feel they would like to discuss further their experience of being interviewed. In order to minimise any potential distress, participants were approached only if they had previously been able to disclose and discuss their experiences of abuse. Ethics approval confirmation is provided in appendix 4.

Measures

Childhood Trauma Questionnaire (CTQ) – Bernstein and Fink, 1998

The CTQ was developed by Bernstein and Fink and was originally presented as a 70 item self-report measure. The reliability and validity were reported in a series of articles (Bernstein et al., 1994; Fink et al., 1995; Bernstein et al., 1997) and the final form was published in 1998. It has been subsequently converted to a short form, which allows researchers and clinicians to identify histories of abuse. The CTQ short form separates abuse into 5 categories; physical, sexual and emotional abuse, and physical and emotional neglect. Separating abuse experience by severity, this measure allowed the recruitment of participants who scored in the moderate to severe levels of abuse to be included. Following the administration of the CTQ, additional questions were asked to identify the perpetrator of the abuse, and the period of time in which it occurred. CTQ questions are provided in appendix 5.

Young's Schema Questionnaire (YSQ). Young, 1998

This 75-item (short form) questionnaire assesses 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 certain degree”. (Young, 1999) The YSQ is a clinical tool and as such has no formal normed scoring criteria. Therefore a participant was seen to highly endorse a schema if their score was over 75% of the highest possible score. This cut off was felt to discriminate our sample. The short form of the YSQ is provided in appendix 6.

Schedules for Clinical Assessment in Neuropsychiatry (SCAN). World Health Organisation, 1995.

The SCAN is a set of instruments used to assess and classify psychopathology and behaviour associated with the major psychiatric disorders in adulthood. This schedule evolved from the Present State Examination initially developed in the 1950s. The SCAN is based on a semi structured interview schedule, which allows the clinician to discover which phenomena are present in a designated period of time. For the purposes of this research sections 16, 17, 18 and 19 of the interview were used. These sections assess hallucinations, thought disorder and delusional ideas. The interview was used not to score the presence of these features, but to allow the researchers to consistently obtain descriptive information regarding delusional beliefs and anomalous experiences across the participant group. This ensured that each participant was systematically asked about different areas of their experience. These descriptions were then summarised in the interview with the participant to represent the main delusional beliefs held. The interview protocol based on the SCAN is provided in appendix 7.

Procedure

Following liaison with multi-disciplinary staff, potential participants were approached by key workers and provided with an information sheet (appendix 1) regarding the nature of the project. In order to establish the experience of childhood physical abuse participants were asked to complete the Bernstein Childhood Trauma Questionnaire and were required to score in the moderate to severe range in order to be included in the

project. Following administration of the CTQ participants were seen for a single interview session. During this session they were asked to complete the Young's Schema questionnaire (YSQ). This was later scored to identify the main schemas present for the participant. Following the administration of the YSQ participants were then interviewed regarding their delusions.

In order to obtain consistent information across the sample, interviewers used a semi structured interview protocol based on sections of the SCAN. This interview checked for beliefs regarding perceptual hallucinations, thought disorder and delusional beliefs. At the end of the SCAN the interviewer summarised the information obtained with the participant and checked they had an accurate understanding of the participant's delusional beliefs. This was then written into a vignette listing the main delusional concerns, explanations and evidence for the beliefs, and the process by which the individual came to hold these beliefs. This vignette was written during the interview process and was checked with the participant for the accuracy of content.

Thematic Analysis

The written account obtained at interview was used as the basis for a thematic analysis to consider the emerging themes of the delusional beliefs described. Using the 2-stage method described by Boyatzis (1998) vignettes were initially read for content drawing on the raw data presented. Codes were then generated from the concepts described with the aim of summarising the data and making the meaning clear. The original codes were then examined for meaning and clustered into categories to represent the sort of thing

being described. This process eventually yielded a number of main themes. During the analysis a separate subsection of themes regarding anomalous experience emerged. In order to adequately consider this area a second analysis was conducted, repeating the thematic analysis purely for content related to anomalous experience.

The themes that had emerged from the analysis were examined for links to abuse material described by participants, as well as considered in the light of the schemas elicited and the severity of the abuse as measured on the CTQ. For an example of this process please see appendix 8.

The Panel Task

Two subsequent vignettes were created for each participant. The first summarised their early experience of abuse and detailed the CTQ scores they reported, and the perpetrator of abuse, their age at onset, the frequency of abuse and the duration of these experiences. The second vignette provided the schemas that the participant had endorsed on the YSQ.

An independent panel of expert clinicians was recruited for the panel task. The four participants with the most severe physical abuse experiences were selected for comparison with 4 participants who had not experienced physical abuse. The panel was asked to complete the following three tasks:

- Firstly, when provided with anonymised vignettes of delusional content, to separate those which they felt would relate to physical abuse, from those who had not experienced physical abuse.
- Secondly the panel was asked to repeat this allocation of anonymised vignettes by the schemas endorsed by participants.
- Finally in the third task the panel was provided with a vignette detailing the early experience, and asked to match the schemas and delusional content descriptions for the individuals concerned.

Reliability and Validity Checks

In order to ensure the reliability and validity of both vignette creation and coding for analysis, a Trainee Clinical Psychologist familiar with the research procedure conducted validity checks. Tapes of an interview were listened to and a vignette created to check for consistency with the vignette created by the original interviewer. In addition following the thematic analysis descriptions for codes were provided and vignettes recoded by the same Trainee Clinical Psychologist. This was then compared to the coding of the original researcher. The two researchers agreed 91% of the time (22 out of 24 codes) with minor questions resolved under discussion, these results are shown in appendix 9.

Results

This study set out to explore a number of questions regarding the links between the experience of childhood physical abuse and the content of delusional beliefs developed later in life. These questions were as follows:

1. For those individuals who have experienced childhood physical abuse what themes emerge in the content of their delusions, and how might these relate to their experiences.
2. Are there links between the schemas of individuals who have experienced physical abuse in childhood and the content of their delusions in adulthood?
3. Can expert raters reconstruct cases accurately matching three vignettes of childhood abuse experience, schema and delusion?

The results section will describe the CTQ results, the thematic analysis of delusional content, results from the schema questionnaire, the potential links across individuals and finally the results from the panel task.

Descriptive Results

Table 1 shows the abuse experiences as reported by the 15 participants on the CTQ.

Table 1. CTQ results

Participant	Physical abuse	Sexual abuse	Emotional Abuse	Emotional neglect	Physical neglect
1	17	25	21	25	13
2	16	5	22	20	10
3	25	15	5	5	9
4	12*	5	18	20	7
5	19	25	21	17	14
6	19	5	22	10	11
7	11	24	18	13	9
8	25	25	23	22	17
9	21	5	24	7	7
10	19	5	16	25	10
11	16	5	17	14	12
12	13	11	14	21	10
13	15	15	12	13	5
14	13	5	13	13	12
15	18	9**	24	22	14

Ranges	None	Low	Moderate	Severe	
<i>Emotional abuse</i>	5-8	9-12	13-15	>16	<i>Moderate</i>
<i>Physical abuse</i>	5-7	8-9	10-12	>13	<i>and severe</i>
<i>Sexual abuse</i>	5	6-7	8-12	>13	<i>included</i>
<i>Emotional neglect</i>	5-9	10-14	15-17	>18	<i>in this study.</i>
<i>Physical neglect</i>	5-7	8-9	10-12	>13	

* There is one question missing from this result

** This score was affected by a report of adult sexual trauma and is therefore not representative of childhood trauma.

From the scores on the CTQ it was clear that emotional abuse was present almost universally across the sample, with 13 of the 15 participants reporting a moderate to severe level of emotional abuse. In addition neglect (emotional or physical) was present in a large proportion of cases (11 of 15 participants).

Descriptive statistics for the CTQ results are shown below:

	Min	Max	Mean	Std Deviation
Physical Abuse	11	25	17.3	4.3
Sexual Abuse	5	25	12.3	8.5
Emotional Abuse	5	24	18.0	5.3
Emotional Neglect	5	25	16.5	6.3
Physical Neglect	5	17	10.7	3.1

Schema

Table 2 overleaf indicates the schema reported by the 15 physical abuse participants.

Appendix 10 provides a full description of each schema.

The most frequently endorsed schema was that of emotional deprivation (8 out of 15 participants), followed by the mistrust / abuse schema (7) and social isolation / alienation (6). Notably, neither abandonment / instability nor failure schemas were endorsed by any of the 15 participants interviewed. Defectiveness / shame, Enmeshment / undeveloped self and entitlement and grandiosity were also infrequent with each of these being endorsed just once.

Thematic Analysis

The thematic analysis of the content of delusional beliefs reported at interview was guided by the staged method reported by Boyatzis (1998). This reading for content revealed five major areas where content clustered and these themes will be described in turn. During the analysis it was noted that all the participants discussed anomalous experiences. A secondary analysis was carried out and is presented here to consider the specific role of anomalous experience, as it appeared a universal experience that may potentially provide the evidence base for delusional beliefs. This analysis was a repetition of Boyatzis stages, reading for content relating to anomalous experience only. In addition this section will consider the schemas endorsed by participants and how this links to the delusional content reported. Finally, by taking individuals in turn, the apparent connections between their abuse experiences, schemas and delusional beliefs will be considered.

1. Others / Threat

This theme emerged in the delusional beliefs of 12 of the 15 participants who had experienced physical abuse. It refers to a cluster of codes referring to the sense of 'others' having a level of interest in, or wish to harm the participant. This could emerge in descriptions of conspiracies, attempts to kill, being put under surveillance or a general sense of concern that others in the community watched, stared, laughed or talked about them.

Examples of these concerns are shown in the excerpts from vignettes below:

P felt that there was a risk of being attacked. P believed this was in particular to test P, to see how strong P is. P felt that people trained in gyms around the community to prepare for these attacks, and that people made marks on the pavement to indicate who was to be attacked.

A believed there was a man in the community who was practising black magic on her. This was the explanation for how things were continually going against her

B believes there is a wire inserted in his body, which connects them to the whole world like a radio system. This was inserted into his arm when in the hospital and allows authorities to monitor B.

These codes of interested others would occur for a variety of reasons, the most common of which were the sense that the participant had something inherently 'bad' about themselves, which resulted in this form of surveillance or persecution.

H felt that people on the street are talking and laughing about her. They say things like 'look at H' 'she's ugly'. It feels like the public are tracking her path, by phoning each other to say 'H's on her way'. As H passes they turn their backs on her because they see something bad in her.

Alternatively the explanation for the persecution or threat may result from 'others' wishing to assert control over the participant.

C was frequently concerned that the managers of the accommodation that he lived in were spying on him through cameras in the light fitting at work. C reported a general belief that people in authority wished to gain control over him.

For another participant this appeared to be suggestive of a more general but unshakeable sense of danger.

F felt a general 'paranoia' about others trying to harm her in some way. This means F must take extra care over the storage of food.

During the interview F reported that this was because people saw her as the enemy, although she did not report at interview anomalous experiences that related to this belief.

Clearly this code suggests a role for altered perception, and a number of participants described anomalous experiences in support of their conclusions.

2. Bad self

Participants frequently reported ideas that appeared to be communicating the notion that there was something in some way wrong with them, or that there was something bad about themselves. This did not appear to be a belief that they internalised, but was reported as relating to how others saw them. This featured in a number of ways but was often linked to the persecutory experiences present in the 'other interest' code. This code was present in 6 of the 15 interviews conducted and made reference to a number of areas by which an individual could feel 'bad', for example due to criminality, homosexuality, body odours, being seen as a 'soft touch' or people being able to sense a more general 'badness' about themselves which could not be described in any more detail. This code was present in the vignette excerpts in the box below.

F reported that her difficulties occurred because people see F as the enemy, and they cannot stand the sight of her.

H felt that people on the street are talking and laughing about her. They say things like 'look at H' 'she's ugly'. It feels like the public are tracking her path, by phoning each other to say 'H's on her way'. As H passes they turn their backs on her because they see something bad in her.

L reported a persistent smell coming from his genitals of dry urine. L felt that people sneezed or cough in his presence because they are aware of the smell.

M persistently hears voices which accuse him of being 'bent' or 'backwards'

In addition there were a further two codes which were provisionally grouped with this code, as participants referred to their concerns about their previous bad behaviour,

particularly their involvement with drug use and how this impacted how this was seen by their community. However, in these cases it seems their concerns were based on a more realistic perception that there were individuals in their community who were aware of their history of drug abuse and the participants described realistic expectations for the difficulties they may experience in the community as a result of these past behaviours.

It can be seen from the examples above that the ‘badness of self’ appeared to relate almost exclusively to other’s perceptions of the participant, rather than an internalised belief. This is supported by the results of the schema questionnaire where participants did not report an internalised belief of their own defectiveness, which is discussed in a later section.

3. Religion / Spirituality

Delusional content that made reference to religious or spiritual beliefs was present in seven of the 15 participants interviewed. For the majority of participants who reported spiritual or religious themes, it appeared to relate directly to anomalous experiences. For example, visions or voices, were frequently explained by contact from the spirit world, or for example being the 'voice of God'. A number of participants also expressed feelings of possession by spirits who would take control of them, their thoughts, or their actions.

B reported that he becomes very powerful and spiritual, and feels he may be possessed by a poltergeist.

G has seen images in her hands ... G believes there is a religious explanation but is not sure. G also hears the voice of a girl from the spirit world.

J experiences a tingling feeling at the back of her neck, which she believes is attributable to someone making contact from the spirit world.

This expressed feeling of contact from the spirit world could be present in both positive and negative ways, for some spirits were helpful, passing on advice or guiding the individual with the powers they experienced. However the contact from the spirit world could be intensely negative, for example some participants described spirits who poked, pinched, sexually assaulted them and put evil into them. Both types of contact can be seen in the example overleaf.

R has felt as if he were being guided by a supreme being. R was in control of time and space ... this was one of the most intensely positive experiences of his life.

A experiences a number of anomalous experiences such as hearing voices and feeling the sensations of spirits touching her body. A had experienced sexual assaults by these spirits whom she felt were under the control of the devil.

Within this sample overtly religious symbols or content was also seen, for example participants who reported the visions they saw of a man in a white robe could be religious in origin, and another who felt the voice they heard was the voice of God. The role of culture in influencing delusional content may play a role in this, as the role of spirit contact, possessed or black magic was noted in a number of interviews all given by participants from non-white cultural backgrounds.

The association with anomalous experiences appears to show some support for the suggestion that the experience of anomalous sensations sparks a search for meaning in individuals, as these beliefs often referred to some form of sensation (olfactory, auditory, visual or tactile) which was given as the evidence for what was happening.

4. Special abilities / Status

This code was given to six participants who within their delusional beliefs described either a talent that others do not have, or who felt they had some form of special status. Talents expressed included the ability to read others minds or influence the world around them in some manner as noted in the examples below.

N also experiences what he calls extra sensory perception (ESP). N reports using this in everyday life and for big sporting events. N's first experience of ESP was in a world cup football final. N reported providing new techniques and strategies for his favoured players. N feels able to provide assistance which determines the outcome of the sporting fixture.

B reported becoming very powerful ... this enables B to experience a number of visions, voices and unusual smells.

The notion of a special status was considered present where participants described being especially selected into a position of authority, or into membership of a powerful organisation as described in the examples below.

S reported a belief that he was a member of a 'program'. This organisation took S under their wing and developed young people who had experienced difficulties.

R has felt as if he were being guided by a supreme being. R was in control of time and space and was the protector of the universe. ...R felt that he could see into people's souls and had the power of telepathy.

Participants who received this code appeared to separate into two groups. The first made more vague references which suggested a sense of power or special status, for example feeling people on the television were singling them out for attention, that

others were jealous of them, or feeling very powerful and able to communicate with everyone.

However there was a second group, where the feeling of special talents, powers or status was much more at the forefront of their descriptions. In one of these cases the participant made direct reference to the abuse they experienced in childhood, feeling that as a result of this hardship he had been singled out to join a group which would provide him with assistance through his life. Two other participants described in detail this type of positive belief. One claimed the ability to communicate with his sporting teams, influencing their success and another reported that he had been placed in a position of protector over the planet. For these three participants the special talent or position was the central preoccupation during their interview, although for two of this group it led to concern about how other would react to their abilities and status, for one attracting the attention of a persecutory organisation which placed him under surveillance.

5. Control

A code for control themes was developed due to a central theme in six interviews of the sense of control being taken away from them, or feelings of powerlessness. For some this associated directly with codes for 'other interest' or 'threat', for example a negative influence would take control in order to expose them to harm. However for some participants, their concern was more related to these feelings of losing control, and beliefs regarding the intention of anyone in authority to take control. Again in this area a number of participants made direct reference to their experiences of abuse, one suggesting he had a tendency to see all people in authority as wishing to exert control over him due to his early experience. Another explained the reason that the feelings of powerlessness were so troubling and preoccupying, was the difficulty she had in tolerating this sensation, which she felt related to the experience of powerlessness in the abuse.

This code was not present solely in those participants who had experienced sexual abuse, neither was it distinguished by gender or severity of abuse as measured on the CTQ. It seems possible therefore that feelings of powerlessness and loss of control are a common theme in both physical and sexual abuse. It is also possible that these feelings may relate more directly to anomalous experiences which are often experienced as being beyond the control of the individual who experiences them.

Examples of the control theme are provided in the extracts from vignettes provided in the box below.

C felt that people were trying to harm him. This belief arose regularly and C was able to identify that it related to any people who were in a position of authority over him. ... C reported at times that he was unable to leave his flat for fear of people who wished to take control over C and make C like a robot under their control.

E reports that their thoughts are being interfered with, some thoughts being taken out and new ones put in. This means that E's thoughts are not his own and it affects his speech and actions so that E does and says things which he does not intend or want to do.

F had a sense of her hand not being under her own control ... F reports trying to separate from her body when she has this feeling as it is very hard to tolerate the feeling of powerlessness.

P reported a sense of unreality, as if neither P nor the people around P were real, but involved in a computer game ... as if programmed to behave in a particular way.

Summary

The thematic analysis did not reveal any consistent differences between the delusional content of individual participants on the basis of age, gender and severity of abuse (as measured by the CTQ scores obtained) or the type of abuse noted on the CTQ score. The links to schema and descriptions of abuse experiences are considered on an individual basis in subsequent sections.

Anomalous experience

It was very apparent that the experience of anomalous experiences was universal in the descriptions of the delusional beliefs. Unsurprisingly these experiences often played a leading role in support of delusional ideas, and a secondary reading of the material was conducted to clarify their role in the formation and maintenance of delusional beliefs.

Anomalous experiences were coded as sensory experiences which others were not aware of. This included hearing voices, seeing visual images and having bodily sensations such as being stroked, pinched or having tingling feelings. Smells, noise and changes in time perception were also coded in this group. Perceptions of change to the body parts also received codes as anomalous experience.

An additional theme arose in the coding regarding sexual content. Although this was at first regarded as a potentially separate theme, it did not in fact arise outside of the context of anomalous experience, and was therefore coded within the anomalous experiences of sensations.

The majority of anomalous experiences were dually coded for the other themes to which they referred. For example the experience of hearing voices that were attributed to the spirit world would be coded for both anomalous experience and spirituality. In the same way perceptual changes relating to a threat from others, would receive this thematic code in addition to whichever anomalous experience was cited as evidence.

There were 35 separate codes given for anomalous experiences, the codes are shown by frequency in the table below.

Table 3. Frequency of Anomalous experiences

Anomalous experience	Number of participants citing
	N=15
Voices	10
Visions	5
Sensations	5
Time differences	1
Noise	1
Perception of body changes	2
Smells	3
Sexual content	4
Thoughts (insertion or removal)	4

The anomalous experience appeared to present in a number of main ways.

1) Attribution to spiritual themes

This was frequently seen with 8 participants making clear statements attributing the experience to some form of contact with the spirit world. Although it would be difficult to establish the pre-existing beliefs of the participants, for many there appeared to be a

potential role for cultural beliefs within the allocation of the nature of the spiritual content. For example individuals accommodated their experiences within culturally acknowledged ideas such as Oujia boards, poltergeists, black magic, and religious figures.

2) Link to abusive experiences

For three participants there appeared to be clear links to their abuse history. One individual reported the experience of sexual assaults, which she attributed to spirits under the control of the devil, but who had experienced sexual assault throughout her childhood by more than one perpetrator. Similarly a male participant who reported the anomalous experience of smelling dry urine had previously recounted how his severe physical abuse arose in the context of him wetting the bed at night, which resulted in beatings throughout his childhood and adolescence.

Although the third participant gave a less clear account, there appeared some suggestion of a relation to his experience of sexual abuse, in the description of anomalous bodily sensations such as something trying to get into his body.

3) Anomalous experiences as evidential role in the development of delusion.

For some individuals the anomalous experience was clearly considered to represent both their initial awareness of something odd occurring, and as the ongoing evidence for which supported their delusional beliefs.

Delusional content appeared to show the maintenance processes whereby perceptual changes of seeing or sensing events were fitted within their belief themes. In addition many participants reported what appeared to be perceptual changes which were not clearly coded as anomalous, but which appeared to represent a change in their attributions. For example individuals cited that people in the street were looking at them, or talking about them – as opposed to the more clearly anomalous experience of hearing the voices of passers-by speak directly about them.

Given the retrospective accounts available it was difficult to establish whether the beliefs or the experiences came first. What was clear however was that for some people the experience of anomalous sensations did not become integrated into their delusional beliefs.

4) Anomalous experiences not related to delusional beliefs.

For a number of participants, their central preoccupation at interview was not the anomalous experience, but other concerns. For some participants this appeared to relate to a clear strategy not to try to make sense of their experiences, for fear that intense speculation regarding the origin of their experiences might send them 'mad'. In other cases however, they appeared to consider their experiences as episodic, or fleeting, and as such had not developed beliefs about them. It remains unclear why some experiences result in complex beliefs, where others are over looked in this way.

Individual Links

Links between Schemas and delusional content.

Where schemas have been endorsed by a number of participants a preliminary analysis was undertaken to consider their links to the early experience details of the participants (such as severity of abuse and type of abuse), and the delusional content themes reported.

The emotional deprivation schema refers to the expectation that one's emotional needs will not be met by others. The 8 participants who endorsed this schema did not differ by gender, abuse type, or CTQ scores from the remaining participants. This schema also did not appear to link to any particular delusional content themes. Similarly, mistrust/abuse schema did not appear to be distinguished by gender, abuse type or severity of abuse in the seven endorsing this more heavily: there were also no evident links to delusional content. Social isolation / alienation was present in 6 participants, 4 of whom experienced both physical and sexual abuse, but the CTQ scores did not distinguish these 6 participants in terms of severity from the other participants. There did not appear to be any consistent links with delusional content themes.

From the preliminary analysis of the schema endorsed there did not appear to be links to the explicit delusional content. From considering the themes which emerged from analysis of the delusional content, it appeared that there were a number that appeared to have similarities to the schema descriptions by Young. The YSQ schema regarding 'defectiveness / shame' is described as 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'. However, despite 8 participants reporting a delusional theme of 'badness of self', only one participant from the fifteen interviewed reported this schema in their completion of the YSQ. This raises an interesting question regarding the lack of correspondence between the delusional belief that 'others' believe them to be 'bad' or 'defective', and the schema self-report whereby they believe this to be true. One hypothetical explanation for this separation would be the role of the delusional belief in expressing a deep-seated belief about themselves that is perhaps denied to their conscious mind. However, it could also support the proposal by researchers that individuals with psychosis have an increased tendency to have externalising attributional styles.

In a similar vein, it appeared that the 'vulnerability to harm / illness' schema could bear some similarity to the thematic code of threat from others. However this schema was endorsed by just 4 participants, despite 12 participants reporting concern regarding threat in the vignette of their delusions. In addition, five participants endorsed a schema of subjugation – the excessive surrendering of control to others because one feels coerced. This overlapped with delusional content coded for control issues in just one case. Just one participant endorsed entitlement and grandiosity – described as the belief that one is superior to other people or entitled to special rights and privileges. 6 participants reported delusional content that was coded for the similar theme of special abilities or status.

This apparent mismatching of some schema content with delusional content was notably pervasive and is considered further in the discussion section, with consideration being given to the notion of delusional content serving as a defensive structure. The absence of a conscious awareness of the schema similar to delusional content could suggest some function of the delusional content in expressing these beliefs without them being internalised and therefore reported as schema.

Independent Panel Results

To examine the consistency of formulation in linking abusive experience, schema and delusional content, an independent panel of clinicians were asked to perform a number of tasks differentiating vignettes describing attributes of participants who had not experienced physical abuse from those who had. The instructions given to the panel are provided in appendix 11.

Qualified Clinical Psychologists with particular interest and expertise in working formed the independent panels with individuals with psychosis. Two panels were selected from four panels made up of clinicians from the Institute of Psychiatry, University of Birmingham, University of Manchester, and University College London.

The early experience, schema and delusion vignettes presented to the panel are included in full in Appendix 12. Vignettes were anonymised and allocated different identifying numbers and initials for the three vignettes.

The following tasks were completed by the independent panels: Firstly from 8 vignettes describing delusional content, the clinicians were asked to hypothesise whether the delusional content would arise from physical abuse, or a differing abusive experience (emotional or sexual). Secondly the panel was provided with 8 vignettes regarding the schema endorsed by participants and again asked to separate these into those who had experienced physical abuse and those who had not. Finally the panel was provided with

early experience, schema and delusional content information for eight participants, and asked to match the experience, to the schema to the delusional content.

The results from the two panels indicated a poor ability to distinguish between the two groups on the basis of the vignette material provided. For the first task where panels were asked to separate delusion vignettes into physical abuse or non physical abuse piles, both panels A and B allocated just two vignettes correctly. In the second task the panel was asked to repeat this exercise for schema vignettes. Panel A was able to allocate 4 vignettes correctly, and Panel B allocated 3 vignettes correctly.

The final task asked panels to recreate individual cases (matching an early experience, schema and delusion vignette). Panel A did not successfully recreate any individuals. They matched one schema vignette and one delusion vignette correctly to the corresponding early experience vignette, but they were not able to correctly match any schema vignettes to delusional content vignettes. Panel B correctly matched four delusion vignettes and 3 schema vignettes to the corresponding early experience vignette. Just 2 schema vignettes were correctly matched to the delusions, and a single case successfully recreated.

Discussion

This study aimed to investigate the following questions:

1. For those individuals who have experienced childhood physical abuse what themes emerge in the content of their delusions, and how might these relate to their experiences?
2. Are there links between the schemas of individuals who have experienced physical abuse in childhood and the content of their delusions in adulthood?
3. Can expert raters reconstruct cases accurately using the three types of vignettes?

The discussion section will firstly consider the information regarding the content of delusions drawn out by the thematic analysis. The role of schemas for the participants in this study and the ability of the independent panel to reliably identify the vignette material provided will then be considered. Finally this section will discuss the limitations of this study, and its implications for future clinical practice and research.

Thematic Analysis

Five main themes were elicited from the 15 participant interviews. These themes centred around ideas of a threat from others, a badness in themselves, content with religious or spiritual themes, a sense of being under the control of others, and ideas regarding the possessions of special status or talents.

Other / Threat

The theme regarding the perception of threat from others was present in most of the interviews conducted (12 of the 15 participants). The prevalence of this theme within this population of adults who experienced physical abuse in their early years may be suggestive of a role of these experiences. Price and Glad (2003) noted that children who experienced physical abuse were more likely to perceive ambiguous stimuli as hostile and it is possible that this attributional bias may continue into adulthood. Valle and Silovsky (2002) noted that survivors of childhood physical abuse were more likely to view the world as more unpredictable and threatening, and Trickett and McBride-Chang (1995) and Van der Kolk and Fisher (1994) have both commented on the potential role of PTSD in heightening a sense of danger about the world and others.

This raises a number of possible roles of early experience in the development of delusional beliefs. Firstly, in relation to posttraumatic stress symptoms, it may be that these individuals maintain a higher level of vigilance regarding threat from the world or others. Secondly, it is possible that this higher level of vigilance is added to by an attributional bias that leads them to interpret ambiguous stimuli as a threat, which may crystallise into a delusional belief regarding conspiracies or threat to themselves over time.

Although these factors may influence the content of delusional belief in this way, it would not explain why some individuals with the same abusive experience do not

perceive threat in the same way, or why this concern would emerge later in the individual's life.

Badness of self

The theme of threat from others was frequently linked to ideas of others perceiving them in a negative manner. This idea of 'badness' could have a straightforward link to abuse experiences, as a number of authors have suggested that the child may internalise the negative beliefs the abuser held about them (Carlson et al., 1997; Valle & Silovsky, 2002). However, from the results from the schema questionnaire it appears that the relationship is not so linear. Despite almost half of the participants describing themes of a 'bad self' at interview, only one participant endorsed the schema regarding a defectiveness / shame about themselves. It appeared therefore that the badness of self was frequently externalised, linked to how others view them (and frequently why others therefore were threatening to them) rather than reported as an intrinsic part of their beliefs about themselves.

It seems possible that for these individuals the delusional belief may represent an externalised characteristic representing contents that would be too painful to acknowledge as a self-evaluation. This notion of delusional beliefs as a defence has been commented on by Bentall and colleagues (2001) who have suggested for some a fragile ego may be protected by external attributions for negative events. These attributions prevent an increase in the awareness of underlying negative self-

evaluations, and therefore maintain self-esteem. The notion of delusions as a defence has been debated in the literature, and Freeman et al. (2000) have argued against this notion. They cite evidence for delusions being a reflection of the emotions of the individual, consistent with the existing ideas about self, world and others. Garety et al. (2001) also note studies by Bowins and Shugar (1998) and Fowler et al. (1998) in support of the role of pre-existing negative schema providing content to the delusion.

In considering these arguments in the light of the schemas endorsed in this study it is possible that there could be a difference between pre-existing schemas, and those endorsed by our participants who had experienced delusional beliefs for a considerable period of time. A prospective study may have seen a higher correlation between delusion and schema that is not present by the time the delusion is fixed and chronic. Roberts's earlier model (1990) suggests a discrete stage whereby delusional beliefs are consolidated, which could potentially change the way the world is seen as attributions are made to external factors, increasing a defended aspect to the way the individual protects against negative self evaluations or discrepancies in self perception.

If schemas were to be mismatched from delusional content in this way, it seems logical that expert raters would have been misled by their presence in the vignette tasks. This could potentially be investigated in further studies perhaps stating this hypothesis for raters to be guided by, or using groups of vignettes with and without schemas to assess the impact on the panel.

However it is also possible that the schemas endorsed on the YSQ may represent a different result than those that might be obtained by a therapist in the process of clinical work. Within a formulation a clinician may well hypothesise about beliefs that would be defended against. It is possible that within this population of participants with long histories of delusions that the YSQ does not provide a valid representation of the schemas present. This could be redressed by a study using clinicians' ratings of schema rather than self-report.

Anomalous experience

Across the themes, which emerged in the thematic analysis, was the role of anomalous experiences. These could be categorised by the different sensations experienced (noise, visions, tactile, olfactory, and perceptual – body changes, thought anomalies etc). Frequently the anomalous experience had a clear link to the content theme that emerged. For example voices that were negative often linked to the perception of threat, and voices or visions were frequently attributed to the influence of the spirit world.

The potential for posttraumatic stress symptoms to emerge later in life following early trauma may suggest a role of trauma in the emergence of anomalous experiences. A number of participants reported sensations such as sexual assaults, or particular smells that appeared to relate to their experiences. This may support the role of flashbacks or intrusive thoughts, images or sensations that may be misinterpreted by the individual who experiences them so many years after the abuse. In the model of delusional beliefs

presented by Maher (1988), a search for meaning would then be instigated which could create a delusional belief system.

As discussed attributional styles (such as a preference for external attributions) may influence the development of particular types of delusional beliefs. Furthermore content may then be influenced by cultural beliefs or other life experiences, thus obscuring any simple relationship between content and early experience.

However, for the participants interviewed in this study, anomalous experiences did not always appear central to the delusional content reported, neither were the experiences their central concern. The selective emphasis on some anomalous experiences, whilst others do not lead to delusional beliefs is not therefore explained by the search for meaning originally suggested by Maher. It is unclear how early experience or beliefs about the self or others may play a role in selecting which experiences participate in delusional beliefs, and which are overlooked.

Expert Panel

From the result of the expert panel it appears clear that at the current time there was little success in attempting to distinguish abuse experiences on the basis of delusional content or schemas. However, from the discussion above it appears that to some extent the role of schema within these research participants may have had a misleading effect on the panel. The lack of matches between schema and delusional content may have lead panel members to assume that these vignettes did not come from the same

individual, whereas a defensive model of attributions would suggest that schemas would in fact be absent where a delusional belief was held. It is an open question whether greater vignette information, or indeed attributional measures aimed at circumventing defences (Bentall et al. 2001) would enable greater accuracy. The lack of success in the present study should not be taken to imply that efforts to formulate delusional content per se, or with vignette materials of this sort, are doomed to failure.

Limitations of the research

In designing the research, an attempt was made to gain systematic information in order to create vignettes that would be testable by an independent panel. In the process of this, it is possible that the depth of information potentially available to a clinician working with an individual over time was necessarily curtailed. By creating vignettes and conducting a thematic analysis on this information, it is additionally possible that meaning was lost. It is hoped that the process of creating vignettes during the interview with participants would ensure that their central concerns were reflected in the final product.

In considering delusional content however, it is also important to acknowledge the fluctuation in concern that may be present. A number of participants described earlier concerns, stating that this experience was not at the forefront of their worries at the current time. It is possible therefore that the same participants re-interviewed may result in differing concerns. It is suggested by Startup (2003) however, that delusional content

can be consistently assessed and this is supportive therefore of the use made of the information revealed at interview in this study.

As with many studies attempting to explore complex phenomenon, the number of participants in this study would hinder the application of these results to a wider population. Similarly there was no established control group of participants without any abuse experiences for comparison purposes. Future research replicating the process with a control group may provide valuable information regarding the potential impact of abuse experiences.

There are a number of methodological limitations in this study that could benefit from further research efforts. The Childhood Trauma Questionnaire (CTQ) does not assess a number of features of abuse. Although this study used a number of follow up questions to identify perpetrator and duration of abuse, information regarding how the abuse was experienced, whether it was disclosed, or how it was coped with in early years, may point researchers towards useful information regarding the genesis of delusional beliefs. It is possible that this added information might improve the ability of independent panels to accurately identify the material.

Clinical Implications

The results from the study did not provide conclusive evidence regarding the influence of early experience on the content of delusion. However from the interviews a number of participants expressed their beliefs regarding the potential role of their early

experience. For clinicians this indicates it may be important to ask questions regarding early experience, and consider this information in formulations of difficulties. Given the mixed picture of the results of this study it seems important too that the multi-dimensional nature of abuse is considered in the formulation and maintenance of delusional beliefs.

In considering the role of schema as measured by the YSQ the results are less than conclusive. The apparent mismatching of endorsed schema to delusions may mark a defensive role of delusional beliefs that would complicate clinical efforts to challenge them.

From the participants varying descriptions of anomalous experience it also appears the exploration of these 'symptoms' is essential to clinical work. For some these experiences appeared key to their understanding, which may allow for the possible challenge of beliefs for example by explaining the potential for posttraumatic stress symptoms to mislead and confuse years later in adulthood. However where anomalous experiences do not appear so clearly linked, care must be taken to establish what role they play and how best to intervene with them. For some anomalous experience were related to cultural or spiritual beliefs, which would need sensitive challenging, and formulation.

The use of the SCAN in this study ensured that participants were asked about a wide variety of delusional beliefs and it was immediately apparent that this structured

questioning frequently revealed secondary and tertiary delusions. It appears that the routine use of such a structured protocol could be of assistance in clearly assessing the needs of individuals presenting at services. Without this careful assessment it is possible that much clinical time could be lost in challenging only a part of the picture, resulting in persistently re-emerging difficulties.

Conclusion

In this study the aims were to investigate the potential links between the experience of childhood physical abuse, and the content of delusional material which emerges later in life. A number of clear themes emerged from the thematic analysis, in particular a concern regarding the threat from others, a preoccupation with a sense of others judging them to be bad, special abilities and talents, and themes of control, religion and spirituality. In addition there appeared to be a number of different ways in which anomalous experiences were interpreted and integrated into their belief systems.

From the interviews with 15 individuals who experienced physical abuse it is clear that the links with delusional content is likely to be more complex than a simply observable relationship. By neither the panel exercise, or the thematic analysis was it possible to make consistent links. However, this result does not lead to a clear rejection of the hypothesised relationship. The counter-intuitive results relating to the role of schema may represent a significant psychological process whereby other less easily captured psychological variables may be at play.

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Part Three

Childhood Physical Abuse and Delusional Content

Critical Reflection

Critical Review / Reflection

For this reflective section I intend to take a chronological approach to the development of the research, considering the issues in design, methodology, ethical considerations, issues raised by recruitment, participants, and the analysis process.

Initial Stages

This research was originally born out of a hope to investigate issues that were arising in clinical work, where abuse histories appeared to play a role for individuals referred for psychological therapy. Within the team around me many service users attended sessions and made oblique or open references to the role of their early experiences, and many expressed statements regarding the impact they felt that this had had upon them.

In developing the research design therefore it seemed important to be able to hear participants' stories, both of their current beliefs, and the experiences they had had in their past. In reviewing the research literature it appeared that individual case studies had been used to illustrate the links between early experience and delusion formation and maintenance (for example Moorhead & Turkington, 2002). Although little in the literature had done this specifically with physical abuse, it seemed helpful to be able to use increased numbers rather than single case studies, and to attempt to create a design whereby the links could be systematically considered.

Methodology

Methodology evolved to create a study that would attempt to combine thematic analysis with information from psychometric measures, and make use of expert rater panels. The use of clinical vignettes to test the ability of diagnosticians to differentiate both psychological and more psychiatric classifications has been noted in the literature. In wishing to establish the potential role of early experience in delusional content it felt important to have an aspect of the study that could independently test these links. This would ensure that any conclusions made could be backed by not only the number of cases considered, but also by an independent result. It was thought that if results were to indicate a reliable distinction of abuse experiences based on delusion and schema vignette, then this material could be helpful to clinicians at the outset of cases, potentially allowing for increased sensitivity to the disclosure of abuse experiences.

In considering the validity of Qualitative research Smith (2003) recommends the use of Yardley's (2000) criteria, which focuses on sensitivity to context, commitment, rigour, transparency and coherence, and impact and importance.

One of the methodological challenges in this research was in the evolution of design necessitated by challenges in recruitment described later. However, in conducting a literature review both prior to the research commencing and continuing throughout the work, I hoped to maintain the sensitivity to the topic recommended by Yardley. This was then supported by reliability and validity checks within the research team to ensure sensitivity to the data.

In writing the empirical paper, and adding this third part of the thesis I would also hope to provide the transparent, coherent account of the research process recommended in qualitative research. The impact and importance of the study at first felt more difficult to interpret. The failure of the expert panel to successfully allocate vignettes to abuse categories, and the struggle to recreate individual cases is likely to be attributable to complex psychological processes, rather than simply refuting the potential for links between abuse and delusional content. The emerging themes of the delusions in this population group may provide data for future research to build upon, and therefore add to this growing field of interest. Recommendations for future research are considered in the discussion section of part two of this thesis, and these include a continuation of the investigation into the impact abuse may have on the formation of delusional content. I feel this is particularly important given the number of participants who came to interview reporting they felt there could be some link between their early experience and later difficulties, but were themselves unable to understand the processes by which this effect might be exerting influence.

Ethical Issues

In obtaining ethical approval for the project there was concern regarding the effects for participants of taking part. Without any direct incentive such as increased input to their care, it was unclear how many individuals would agree to meet with us, and how they might experience our interviews. Again a turn to the literature (Lothian & Read, 2002) emphasised the reported value of being able to discuss early experience with an

appropriate clinician, and mechanisms were put in place to deal with any distress, which could emerge.

At this early stage, it was unclear how much information may have been wanted by care teams, but there was a concern that if participation resulted in disclosure of abuse to the wider team, individuals may have felt less inclined to participate. It was decided therefore, that although individuals would only be approached when abuse had been disclosed and was recorded in medical files, feedback from the research in the form of psychometric material or interview data would not be made available to other mental health professionals involved.

This decision raised the potential difficulty of withholding information from other professionals that could add to their understanding of the individual concerned. It was felt however, that assurances of confidentiality needed to be made to participants, both to secure their involvement, and also to minimise any potential distress from taking part. It was agreed to consider any individual applications for information should concern arise from clinical teams, however in the event, whilst conducting the research we did not receive any requests for interview information from other clinicians.

The experiences of participants are considered in detail in the subsequent sections.

Recruitment

The recruitment of individuals for this study was done by contact with community mental health teams and inpatient units. In addition participants were recruited from referrals to the psychological therapies service where the research was conducted. During the process of recruitment it was immediately apparent that for the vast majority of individuals using inpatient services, there was extremely limited information regarding their early experience. Despite the widespread acceptance of the role of early experience in the cognitive model of mental health difficulties, for individuals in the inpatient setting this area of their experience appeared to be overlooked. Frequently my conversations with primary nurses and key workers did not add to the sparse information located on file.

In my approaches to staff members I did note an awareness of abuse issues within mental health in general. Many staff reported their own hypotheses that some symptoms of psychosis could relate to particular types of abuse, and many were enthusiastic regarding the potential to research this area. However, this interest and hypothetical thinking did not appear to filter to the individual level, unless abuse was documented it did not seem to be routinely discussed. Therefore in cases where abuse had not been disclosed, the possibility of this type of experience was overlooked. This supports the research conducted over 15 years ago by Briere and Zaidi (1989) who report finding just 6% of files recording abuse, with a rate that soared to 70% when these individuals were asked directly about their experience.

During the initial stages of recruitment therefore, I at times adopted an awareness raising approach. This involved presenting the planned research as well as working with other clinicians with audit projects regarding the documentation of abuse. In addition to highlighting the advantages of routine screening for early experiences, it was helpful to make available clinical tools such as questionnaires to assist staff in approaching this difficult area. The end impact of the project within the service is discussed further in the concluding sections.

The experience of recruitment differed within community mental health teams, who appeared to have more detailed information regarding their ongoing caseloads – perhaps due to their increased contact with the individual in the community. Within community teams there appeared to be much increased concern regarding the suitability of participants for the research, with many members of staff appearing to take a protective role, declining to approach individuals on their case load.

It became clear that the subject matter of abuse created anxiety for professionals in a number of ways. It is possible that in those cases where individuals do not disclose abusive experiences, there is concern from staff regarding how to enquire, and potentially how to respond to disclosures when they occur. In addition staff appeared to express concern regarding the experience of discussing abuse for potential participants. Lothian and Read (2003) have reviewed the literature around mental health professional's inquiries about abuse and they cite Young's (1999) survey of professionals which notes the most common reasons for not discussing abuse were a

feeling that it was not the main concern at that time, or that it would distress the individual to be asked. This highlights the need for the further dissemination of research which indicates individuals welcome the opportunity to discuss their experiences (Lothian & Read, 2003) and who see their abuse experiences as central to their adulthood difficulties (Ritscher et al., 1997; Rodgers et al., 1993).

Our experience in conducting the research was supportive of these findings. I found once participants had been approached their willingness to participate seemed high. Indeed, the biggest challenge to recruitment was the identification of individuals, and making initial contact. Once contacted the majority of individuals agreed to be interviewed. For all participants who were living in the community, travel to the interview was paid for, however more than one participant initially declined the expense money and were apparently motivated to attend in order to tell their story.

In addition on one occasion a participant who had been approached and declined as he felt his mental state was not stable enough, made unsolicited contact two months later, asking if he could book an interview if the project was not completed. Similarly individuals who had experienced considerable difficulties in attending routine appointments attended interviews with minimal prompting or support.

The initial design of the research called for the recruitment of individuals who had experienced single categories of abuse so that comparisons could be made between those who had experienced physical abuse and those who had not. In recruitment

however it became apparent early on that physical abuse was rarely present without emotional abuse and neglect. This appears to be a feature of the population, as Bernstein et al. (2003) found a similar pattern. However I also found that it was difficult to recruit individuals who had experienced sexual abuse without experiences of physical abuse to act as a comparison group for the thematic analysis and panel exercises. It rapidly became necessary to rethink the comparison groups and the inclusion criterion was adapted. This led to the eventual collection of data on a small number of emotionally abused participants who did not experience physical abuse for comparison purposes.

It seemed within our sample that the neat categorisation of participants into single abuse types was simply not possible. What remains unclear is whether this is a feature of the abused population in general, or is unique to my sample. If this multiple type of abuse experience is common in the abused population, future research would do well to consider how they can compare experiences, and what the combination effects of multiple abuse experiences may be.

Participation Experience

The Interview

The interview process lasted for an average of an hour and a half, although for some participants it took considerably longer and was split into more than one session.

As would be expected, the area of the interview that appeared most sensitive was the discussion of the Childhood Trauma Questionnaire. Participants were asked to answer questions regarding the identity of the abuser, the frequency of abuse and its duration. For a number of participants, the disclosure of the perpetrator was difficult and I felt the issue of stigma in naming family members appeared to have an effect on how difficult it could be to provide this information. A small number of participants made requests not to discuss this information, but were able to write the details on the CTQ form for the researcher to see.

Clearly for a number of participants this part of their life remained an extremely difficult subject area. On only one occasion though did an interview have to be interrupted because of emotional distress, which supported my conclusions that participants welcomed the opportunity to discuss their experience.

A number of participants made specific reference to their early experience in their understanding of their current difficulties. This was both in explaining the formation of their delusional beliefs (for example feeling that they were seen as bad or evil because

of what they had gone through, or being selected for special attention because of their childhood difficulties), and in their explanations for distress (for example the reason why bad luck pursued them through their life, or why they found particular sensations distressing). These references to the past were rarely described in a coherent story however. Participants seldom made these connections with regard to separate symptoms (such as hearing the voice of an abuser, or experiencing a flashback) but appeared curious about the impact of their experiences, and potentially open to thinking about it within the interview or a therapeutic setting.

Perceptions of physical abuse

During the recruitment process I noticed that many individuals described physical abuse in the more socially acceptable terms of punishment. A number of participants made direct reference to the level of violence that they experienced in the home being considered normal. For some normality was defined by siblings sharing the same treatment, although other participants reported that this was normal child rearing practice in the time or location where they were raised. This raised the question of how an experience of physical abuse might differ within homes and communities.

Corporal punishment has been debated in the literature as a number of authors feel it lies on a continuum with abusive experiences (Gershoff, 2002). This appeared to be supported by the reports of our participants who described 'punishments' which were on the ratings of the CTQ indicative of physical abuse. The impact of such experience has been shown in the literature to extend through to adulthood. It is noted to fail to

teach the lessons that it intends, promoting children's external attribution for their behaviour, failing to teach the effect of their behaviour on others, and promoting hostile attributions towards others (Hoffman, 1983; Patterson, 1982; Smetana, 1997). These suggestions in the literature appear similar in a number of respects to the suggested impact of abuse, and no doubt the debate regarding the acceptability of corporal punishment in modern society will continue.

It was apparent from the outset that the use of the CTQ in the inclusion criteria allowed for a more independent assessment of abuse. However it does not consider how the experiences were interpreted. Frequently as a researcher questions appeared in my own mind as to how the experience would differ for an individual who was 'singled out' to one who was brought up believing their treatment was correct. The limited scope of this research precluded a further exploration of how the abuse was experienced, which as an interviewer could feel limiting. However it felt important to maintain a balance between pursuing more detail and being sensitive to the emotional content of the stories.

I did find that the experience of childhood abuse was inevitably a complicated one. For example one participant compared the experience of an emotionally abusive parent who wished the child did not exist, to how the other parent made them feel special and loved, sadly due to engaging them in abusive sexual practices. As a researcher listening to these experiences could engender a hopeless feeling, for an individual whose early messages regarding relationships with others were so tragically confused. It also highlighted the theoretical emphasis on interpretation and meaning. For this participant

they reported the emotional abuse to feel more damaging at the time, whereas the sexual involvement to some extent appeared to provide an experience of affection and caring. Clearly research which attempts to categorise experience by abuse type alone is challenged by these stories, as it would take considerable time to unpack the effect of each aspect of these experiences.

This meaning and interpretation of abuse is added to by other details of the abuse such as the ability of the child to disclose the experience and receive protection at the time. Although disclosure was not specifically enquired about at interview, it was noticeable by the interviewer that some participants had been able to discuss their abuse within confiding relationships. The ability to disclose and discuss the abuse both as a child and later in life may improve the resilience of the individual, and have an impact on how they are able to make sense of their experiences and how this affects them in adulthood.

Follow up

Despite arrangements for the participants to be offered follow up appointments should they feel distressed by their experience at interview, there were no participants who chose to take up this option. Neither was there any subsequent contact from associated mental health professionals reporting any changes following interview.

On a number of occasions though individuals did ask at the end of the interview about psychology, expressing an interest in pursuing therapy and asking questions about how it may be able to be helpful to them. In taking the time to explain the process and

options available for therapy, it was apparent to me that many of the participants had had few contacts with mental health services at their own instigation, and they seemed to have had limited opportunities to discuss at length their mental health difficulties or early experience. I hoped that in facilitating referrals to the psychological therapy service this opportunity might be available for them. However it was also clear to me that for some their current beliefs about their difficulties may require a more creative and flexible approach than is usually available. I had a sense that for many it may have been helpful to be aware of the similarities of their own concerns to others with similar experiences, indeed this was often cited as a helpful side effect of contact with mental health services.

Analysis

In drawing on qualitative methods I hoped that the research would be able to identify information without stretching the limits of the data obtained. Thematic analysis described by Boyatzis (1998) was utilised as more interpretative approaches were felt to be unsuitable, largely due to their reliance on richer data beyond the scope of the vignette material obtained.

By using the coding stages described by Boyatzis a number of common themes became apparent. In this process however it was unclear how emerging themes may have been affected by my own beliefs and biases. In reliability checks I obtained a degree of confidence in the themes, since there was an over 90% agreement in coding by another researcher.

Unfortunately given the limitations of the project it was not possible to revisit with participants the emerging themes and potential links. This process of cyclical return to the data is recommended in a number of qualitative methodologies including grounded theory (i.e. Charmaz, 2003) as a way of ensuring the emerging themes are grounded in the data and not influenced by the pre-existing concerns of the researcher. For a number of participants who were particularly expressive and insightful this may have been an opportunity to both share and gather a deeper understanding of the issues involved. The potential for conducting more extensive research interviews may have also opened alternative viewpoints and highlighted other incidents that affected either the interview or the delusion formation, and allowed for a richer analysis to be conducted. In creating the vignette used for analysis however, I hoped to provide some opportunity for participants to amend and correct my description of their delusional beliefs, ensuring that the data did accurately represent their concerns.

In conducting an expert panel exercise, it was hoped that the research could test further the potential for the clinical vignettes to provide useful information regarding abuse histories. From the design stage it was hoped that the ability to distinguish delusional or schema information could be of value to clinicians in therapeutic work. The reality of the analysis was a far more complex interaction between experiences, schema and delusion that may not have been adequately captured by the panel exercise. Feedback from the panels noted the difficulty they experienced in completing the task, and a

reliance on their own clinical judgement rather than drawing on any particular area of research.

Clinical Practice

In reflecting upon the research I will consider my personal reflection for my own practice, and the implications for clinical practice in general before highlighting service implications and issues.

The process of conducting research, which specifically made enquiries into abuse experiences, has had wider implications on my own practice. Conducting separate assessment sessions for ongoing clinical work, it felt immediately clear that if the clinician does not open the space to bring abusive experiences into discussion, it would be an overwhelming topic to introduce. The sense of anxiety that I could feel as a clinician in asking about abusive experiences gave some insight into the strength that would be required to bring this topic to the attention of a mental health professional. Similarly my anxiety about the response I would receive in asking these questions, lent me some insight into what it might be like to attempt to disclose, and the anxiety of attempting to predict how others may respond.

The complications of abuse experiences were also highlighted for me during the course of these interviews. When corrected in the administration of the CTQ by an individual who reported that they had felt very special and loved due to their involvement in sexual abuse with one parent, I was given some small insight into the challenge in

integrating their experience for this participant. This instilled for me a sense that we cannot predict how people will respond to their experiences, and how sensitive we must be as clinicians to respond to all of the emotions associated with abuse experiences, rather than focusing on the traumatic responses.

For clinicians it appears that there are a number of important issues to be further considered. The recruitment phase of the project provided information regarding the high frequency of multiple abuse experiences, which need to be addressed in clinical work. It would be important for clinicians not only to assess for different types of abuse, but also to consider the differing meaning and impact these experiences may have had. It is possible that the mismatching of the Young Schema Questionnaire to the delusional content may represent a defensive structure to delusions which clinicians would do well to be aware of, suggesting a richer vein of beliefs and concerns that may be held below the surface of standard psychometric measures. In addition the use of a structured format to interviewing about delusional beliefs resulted in a frequent yielding of more than one delusional belief, which may or may not be linked to each other. The use of more structured interview formats may assist in gaining a more accurate picture of delusional beliefs and how they cause difficulties and distress.

Service Implications

As I have discussed the initial recruitment stages of the research at times took on an awareness raising approach to an issue that appeared largely hidden. I hoped that for participants who took part the research could in some small way represent a validation

of the importance of their experiences. A number of participants took the opportunity to ask informal questions about how a psychological approach might be able to help them explore their experiences. For staff, the opportunities that the researchers had to explain their rationale for the project may have increased their awareness of the difficult early experiences of the individuals for whom they were caring.

As the project progressed, more researchers became interested in pursuing these lines of inquiry, and the research team expanded to include more psychology and medical staff. At the time of writing an audit of abuse disclosure at interview was being conducted to compare to an earlier audit of abuse disclosures held on files alone. I hope that this sort of audit project will add to the awareness of the prevalence of abuse in these populations, and demonstrate the importance of verifying old records and information.

The apparent reluctance of staff to make inquiries about abuse was also noted and acted upon. Using a working hypothesis that staff were anxious about causing distress, or not knowing how to either ask or respond to these issues, tools and training was offered by the department to the ward teams. It was hoped that the wider availability of questionnaires and training would allow for an easier approach to this delicate subject matter, and could provide a more routine approach to raising these issues.

Ongoing work to feedback the information and questions raised by this project is planned, and it seems essential for both researchers and clinicians that the impetus of this increased awareness and interest is not lost.

Summary and Conclusion

This research evolved from a clinical interest in the experience of abuse and the potential links to more extreme psychopathology such as psychosis. In conducting the research there were suggestions from participants of a link, but few coherent stories of how early experience could have an impact. As a researcher this project raised multiple questions for me about the impact of early experience, as the effect appears to be a complex interaction of a number of features. This raised methodological questions about how best to tap into this material, and ethical issues about how to approach future research with participants who could be distressed by more in depth interviews.

At a service level there appeared to be a positive awareness raising aspect of the research's persistent efforts to identify participants. This at times took the form of challenging the reliance on previous case notes, and encouraging more routine interviewing to verify the early experience of participants.

From a more academic perspective the research appears to support the ongoing effort to develop more complex integrative models of delusional formation, maintenance and content. A potential role of early experience on the content cannot be discounted, but the complexity of the interpretations and meaning of experience is likely to be central to future explanations. It is hoped that in pursuing these questions research will be able to maintain the difficult balance between the complex models of delusions with the

clinical need for useful, reliable information, which can help individuals seeking further understanding of their experiences.

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Appendix 1). – Information sheet for Participants

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 2. – Consent Form

Centre Number:

Study Number:

Participant Information Number for this study:

CONSENT FORM

Title of Project

Name of Researcher

Please initial box

1.	I confirm that I have read and understood the information sheet	
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 ensure that the study is being carried out correctly	
4.	I agree to take part in the above study	

Name of patient

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

Date

Signature

Name of researcher

Date

Signature

1 for participant, 1 for researcher, 1 to be kept with hospital notes.

Appendix 3). Letter to care teams to confirm participation.

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 regarding 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 20 participants 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 2005.

We hope to find out about three main areas of participants lives: Firstly their childhood, focussing 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 from interview with the participants, including questionnaires and checklists (the Childhood Trauma Questionnaire and the Youngs' Schema Questionnaire and the SCAN). In addition we hope to access relevant information in the medical notes. Some of this information will be shown to three other psychologists, but any identifying information will be removed to preserve participants 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 all participants will be offered subsequent appointments at the Psychology Department should the interview raise issues which they would like to discuss further. If you have any concerns about the individual named above 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.

Helen Curr, Trainee Clinical Psychologist
Emma Brett, Trainee Clinical Psychologist
John Rhodes (Supervisor & Consultant Clinical Psychologist).

Appendix 4) Ethics Approval Letters

Appendix 5). CTQ Questions

Childhood Trauma Statements for abuse type

Emotional Abuse

- 3. People in my family called me things like “stupid” or “lazy” or “ugly”.
- 8. I thought my parents wished I had never been born
- 14. People in my family said hurtful or insulting things to me
- 18. I felt that someone in my family hated me
- 25. I believe that I was emotionally abused

Physical Abuse

- 9. I got hit so hard by someone in my family that I had to see a doctor or go to the hospital
- 11. People in my family hit me so hard that it left me with bruises or marks
- 12. I was punished with a belt, a board, a cord or some other hard object
- 15. I believe that I was physically abused
- 17. I got hit or beaten so badly that it was noticed by someone like a teacher, neighbour, or doctor.

Sexual Abuse

- 20. Someone tried to touch me in a sexual way, or tried to make me touch them
- 21. Someone threatened to hurt me or tell lies about me unless I did something sexual with them
- 23. Someone tried to make me do sexual things or watch sexual things
- 24. Someone molested me
- 27. I believe that I was sexually abused.

Emotional Neglect

- 5. There was someone in my family who helped me feel that I was important or special ®
- 7. I felt loved ®
- 13. People in my family looked out for each other ®
- 19. People in my family felt close to each other ®
- 28. My family was a source of strength and support

Physical Neglect

- 1. I did not have enough to eat
- 2. I knew that there was someone to take care of me and protect me
- 1. My parents were too drunk or high to take care of the family
- 6. I had to wear dirty clothes
- 26. There was someone to take me to the doctor if I needed it ®

Note: ® indicates a reversed scored item

Appendix 6). Young Schema Questionnaire – Short form

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. _____ I feel that people will take advantage of me
2. _____ I feel that I cannot let my guard down in the presence of other people, or else they will intentionally hurt me
3. _____ It is only a matter of time before someone betrays me
4. _____ I am quite suspicious of other people's motives
5. _____ I'm usually on the lookout for people's ulterior motives
6. _____ I don't fit in
7. _____ I'm fundamentally different from other people
8. _____ I don't belong, I'm a loner
9. _____ I feel alienated from other people
10. _____ I always feel on the outside of a group
11. _____ No man / woman I desire could love me once he / she saw my defects
12. _____ No one I desire would want to stay close to me if he / she knew the real me
13. _____ I'm unworthy of the love, and attention, and respect of others
14. _____ I feel that I am unlovable
15. _____ I am too unacceptable in very basic ways to reveal myself to other people.
16. _____ I can't seem to escape the feeling that something bad is about to happen

17. _____ I feel that a disaster (natural, criminal, financial or medical) could strike at any moment
18. _____ I worry about being attacked
19. _____ I worry that I will lose all my money and become destitute
20. _____ I worry that I'm developing a serious illness, even though nothing serious has been diagnosed by a physician
21. _____ I'm the one who usually ends up taking care of people that I'm close to
22. _____ I am a good person because I think of others more than of myself
23. _____ I'm so busy doing for the people that I care about, that I have little time for myself
24. _____ I've always been the one who listens to everyone else's problems
25. _____ Other people see me as doing too much for others and not enough for myself
26. _____ I can't seem to discipline myself to complete routine or boring tasks
27. _____ If I can't reach a goal, I become easily frustrated and give up
28. _____ I have a very difficult time sacrificing immediate gratification to achieve a long range goal
29. _____ I can't force myself to do things I don't enjoy, even when I know it is for my own good.
30. _____ I have rarely been able to stick to my resolutions
31. _____ 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
32. _____ In general, people have not been there to give me warmth, holding and affection
33. _____ For much of my life, I haven't felt that I am special to someone
34. _____ 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

35. _____ I have rarely had a strong person to give me sound advice or direction when I'm not sure what to do
36. _____ I find myself clinging to people I'm close to, because I am afraid that they'll leave me
37. _____ I need other people so much that I worry about losing them
38. _____ I worry that people I feel close to will leave me or abandon me
39. _____ When I feel someone I care for pulling away from me, I get desperate
40. _____ Sometimes I am so worried about people leaving me that I drive them away
41. _____ Almost nothing I do at work (or school) is as good as other people can do
42. _____ I'm incompetent when it comes to achievement
43. _____ Most other people are more capable than I am in areas of work and achievement
44. _____ I'm not as talented as most people are in their work
45. _____ I'm not as intelligent as other people when it comes to work (or school)
46. _____ I do not feel capable of getting by on my own in everyday life
47. _____ I think of myself as a dependent person, when it comes to everyday functioning
48. _____ I lack common sense
49. _____ My judgement cannot be relied upon in everyday situations
50. _____ I don't feel confident about my ability to solve everyday problems that come up
51. _____ I have not been able to separate from my parent (s), the way other people my age seem to
52. _____ My parent (s) and I tend to be over involved in each other's lives and problems

53. _____ It is very difficult for my parent (s) and me to keep intimate details from each other, without feeling betrayed or guilty
54. _____ I often feel as if my parent (s) are living through me – I don't have a life of my own
55. _____ I often feel that I do not have a separate identity from my parent (s) or partner
56. _____ I think that if I do what I want, I'm only asking for trouble
57. _____ 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
58. _____ In relationships, I let the other person have the upper hand
59. _____ I've always let others make choices for me, so I really don't know what I want for myself
60. _____ I have a lot of trouble demanding that my rights be respected and that my feelings be taken into account
61. _____ I am too self conscious to show positive feelings to others (e.g. affection, showing I care)
62. _____ I find it embarrassing to express my feelings to others
63. _____ I find it hard to be warm and spontaneous
64. _____ I control myself so much that people think I am unemotional
65. _____ People see me as uptight emotionally
66. _____ I must be the best at most of what I do; I can't accept second best
67. _____ I try to do my best; I can't settle for "good enough"
68. _____ I must meet all my responsibilities
69. _____ I feel there is constant pressure for me to achieve and get things done
70. _____ I can't let myself off the hook easily or make excuses for my mistakes
71. _____ I have a lot of trouble accepting "no" for an answer when I want something from other people

72. _____ I'm special and shouldn't have to accept many of the constraints placed on other people
73. _____ I hate to be constrained or kept from doing what I want
74. _____ I feel that I shouldn't have to follow the normal rules and conventions other people do
75. _____ I feel that what I have to offer is of greater value than the contributions of others

Appendix 7). Protocol for interview (Incl. SCAN).

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 / frequency of abuse, duration of abuse.

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?

Written summary of main delusional difficulties – To be checked with participant during interview

Appendix 8) Example of coding analysis

<p>This participant was not able to give a coherent account of the difficulties that they had. During the interview B focused on different areas of their difficulties and how it was managed with medication. Towards the end of the interview B focused on a number of main problems:</p> <ol style="list-style-type: none"> 2. That there was a wire in B's body, that connects them to the whole world like a radio system. This had been inserted into B's arm when in the hospital and it allows authorities to monitor B as well as allowing B to connect to people, radios and televisions. 3. The participant reported that they become very powerful and spiritual in themselves, and feels that they might get possessed by a poltergeist. This enables B to have a number of contacts with visions, voices and experiencing unusual smells. In addition during these times that B was able to make contact with dead relatives, inviting them into B' body and feeling sensations in their body associated with them (for example that B's toes were flaking off because B's Grandfather had gangrene in his toes. 4. B also reported a belief that their genitals changed when on medication, becoming smaller and thinner, and when B stopped taking it, B's genitals becomes numb, as if it is not part of their body and could easily be pulled off. <p>B suggested some possible explanation for why the authorities were persecuting them, and this was that B' family had been connected with criminal activities for some time (dating back to the Kray era in East London). This is a link which B believes when not well, but doubts when well.</p>	<p>Initial Codes</p> <p>Connection to technology</p> <p>Surveillance</p> <p>Powerful</p> <p>Possession Special abilities Contact with spiritual world Anomalous experiences – visions, voices, sensations AE – Body change**</p> <p>Criminality</p>	<p>Grouping</p> <p>Special Abilities</p> <p>Other / Threat</p> <p>Special Abilities</p> <p>Religion / Spirituality</p> <p>Anomalous Experience*</p> <p>Badness of self</p>
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* Anomalous experiences were further considered separate to the thematic analysis and were coded for presence in the axial coding

** This was originally considered potentially sexual as it referred to the genital area, but return to the interview material suggested it was more about the sensation of his body changing and not being his own than a sexual theme, it was therefore coded for anomalous experience.

Appendix 8 continued ... Original Codes & Groupings

Other interest / talking	Other Threat
Other – mocking	
Surveillance	
Threat to self / of harm	
Conspiracy / persecution / enemy	
Generic threat	
Seen as criminality	Badness of Self
Homosexuality (as badness about self)	
Seen as stupid	
Smell from self	
Seen as soft touch	
Punishment	
Badness of self (general)	
God / Devil / Evil	Religion / Spirituality
Possession of self	
Possession of others	
Contact with spirit world	
Black magic	
Presence of spirits	
Control taken	Loss of Control
Powerless feeling	
Unreality / programmed	
Communication with others	Special Abilities / Status
Connection to technology	
Guided by special power	
In position of power	
Membership of powerful organisation	
General special gifts	
General feeling of power	
Other jealousy	
Sexual content	<i>These codes became part of the anomalous experiences codes</i>
Sexual sensations	

Appendix 9). Reliability Checks

Vignette 7

	Other threat	Bad self	Religion	Control	Special abilities / Status	Anomalous experience
First Coder	Present	Not present	Present	Present	Present	Present
Reliability check	Agreed	Disagreed	Agreed	Agreed	Agreed	Agreed

Vignette 12

	Other threat	Bad self	Religion	Control	Special abilities / Status	Anomalous experience
First Coder	Not present	Present	Present	Not present	Not present	Present
Reliability check	Agreed	Agreed	Agreed	Agreed	Agreed	Agreed

Vignette 13

	Other threat	Bad self	Religion	Control	Special abilities / Status	Anomalous experience
First Coder	Present	Present	Not present	Not present	Not present	Present
Reliability check	Agreed	Agreed	Agreed	Agreed	Agreed	Agreed

Vignette 19

	Other threat	Bad self	Religion	Control	Special abilities / Status	Anomalous experience
First Coder	Present	Not present	Not present	Present	Present	Not present
Reliability check	Agreed	Agreed	Agreed	Agreed	Disagreed	Agreed

Appendix 10). Schema descriptions

Early Maladaptive Schemas and Schema Domains

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.

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.

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.

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.)

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 11). Instructions for Expert Panel

Dear.....

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 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.

Task One:

In these tasks you are being asked to distinguish individuals who reported physical abuse, from those who reported other forms or combinations of abuse (sexual, 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 physical abuse and those which you think arise from a combination of other forms of abuse (i.e. sexual, emotional or neglect)
- Please read the delusion vignettes and separate into those which you think belong to a participant who has experienced physical abuse and those which you think belong to a participant who has experienced a combination of other forms of abuse (i.e. sexual, emotional and neglect)

Task Two:

In this task you have been given the abuse history, schema and delusion vignettes for the 8 participants. 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

Appendix 12). Delusion Vignettes sent to panel

Initials have been changed to preserve anonymity and gender neutrality, and to prevent the panel matching by identifying features in other vignettes.

4	<p>D</p> <ul style="list-style-type: none">• D hears the voice of D's father calling. This has increased in recent weeks following D's father's death. D also hears voices that tell D to commit suicide and call D 'dirty' and 'failure'. They often make nasty comments. D does not know who these voices belong to.• D has a strong sense that there are people planning to attack. D hears a thought echoing repeatedly, 'you'll be attacked, attacked, attacked....'• D feels that his/her body has a strange smell, like mothballs, even when recently bathed.• D often finds his/her mind goes blank – as if D has just woken up – and can't remember what was being thought about before.• In the past, D saw a UFO and felt that it was sending bad signals through the letter box. D also saw white spiders on the ceiling. D hoarded the household rubbish in the flat because D didn't want the neighbours to think D was dirty.• Sometimes D's thoughts are broadcast on TV, for example, a message predicting the end of the world, and D feels like it is a message especially for D. <p>D explains these experiences as punishment for the abuse in the past.</p>
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7	<p>G</p> <ul style="list-style-type: none">• G has seen images in G's own and other people's hands, for example a man in a white robe and the winged horse, Pegasus. G believes there may be a religious explanation but is not sure.• G also hears the voice of a girl from the spirit world. The girl says bad things, for example, 'you're rubbish' but also helps in some ways, for example, helping G out of bed in the morning. G believes that the girl wants G dead. The girl occasionally talks to a man about G but G can never hear what the man says. The girl takes thoughts out of G's head and also puts them in. Sometimes the girl speaks through G's mouth, and sounds just like G. The girl is jealous of G, for example of G's spirituality and lifestyle before hospital• G believes that G's features have changed, for example, G's nose and lips.
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9	<p data-bbox="311 380 335 414">'I'</p> <ul data-bbox="351 436 1228 952" style="list-style-type: none"> <li data-bbox="351 436 1228 526">• 'I' has seen beads and energy balls. 'I' can see the energy, but not through normal vision. 'I' also experiences an 'advice system', through psychic communication. <li data-bbox="351 560 1228 627">• 'I' has heard things (not voices) for which there is no ordinary explanation, but this has happened only once. <li data-bbox="351 649 1228 716">• 'I' also reported that at times he/she had felt that 'I' possessed a type of magnetism that meant people were attracted to him/her in a positive way. <li data-bbox="351 739 1228 862">• 'I' reported the shape of his/her body had changes in puzzling ways, feeling, at times, that the bones were sticking out, although objectively 'I' reported that their body was never particularly thin. This appeared to be related to concerns about eating in public places which 'I' has for some time been unable to do. <li data-bbox="351 884 1228 952">• 'I' also reported over sensitivity, picking up moods from rooms and places, which 'I' felt was spiritual in origin. <p data-bbox="311 974 1228 1030">'I' reported not putting all of this together into a theory because 'I' does not have the scientific knowledge or background (ie in physics) to explain.</p>
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11	<p data-bbox="311 1142 335 1176">K</p> <ul data-bbox="351 1198 1228 1736" style="list-style-type: none"> <li data-bbox="351 1198 1228 1355">• K has believed that God had died, leaving K in a position of authority. When K's father died, this was as if God had passed away, leaving K in charge. During the interview K fluctuated between reporting that K was responsible, and reporting that it was K's son in whom it was possible to see God and K's father. <li data-bbox="351 1355 1228 1444">• K reported when first unwell having beliefs about a girl who was renting a room from K's mother. K believed that this woman possessed the house using some form of voodoo. <li data-bbox="351 1444 1228 1590">• K believed was being possessed by devils coming into K's body. K explained a complicated system whereby people around K were able to swap in and out of bodies at will. This was explained by the example of K's ex-partner's father being one of 12 tribes of Israel and this ex-partner having turned "bad", swapping into people's bodies. <li data-bbox="351 1590 1228 1736">• K has believed at times that K has had multiple children who are scattered around the world, but K is only allowed access to them one at a time. K reported believing that the plants in K's mother's house came alive when K blessed them and the plants were like children who were being killed. K reported at times seeing these children in plants, furniture and trees. <p data-bbox="311 1769 1228 1892">K reported the main evidence in support of the beliefs was the experience of thinking that K's family were talking about K, and planning to take K's child away. In addition, K reported people in the street talking about K loud enough for K to hear, and the content referring to K.</p>
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12	<p data-bbox="367 380 391 414"><i>L</i></p> <ul data-bbox="414 436 1300 862" style="list-style-type: none"> <li data-bbox="414 436 1300 683">• L described a period of time several years ago when L had experienced auditory and visual hallucinations. L's aggressive, growling voices would command L to hit people. At this time, L also experienced sensations of being poked, prodded and pinched or occasionally of a woman stroking L's hair. L would experience a visual image of a woman dressed in white, who L felt was related to L's use of a ouija board. In addition L would see a friend who had killed himself by setting himself alight. This 'burned' man would appear and stare at L. <li data-bbox="414 705 1300 862">• More persistently L reported a belief that there was a smell coming from L's genitals of dry urine. L reported that this came from the skin of the genital area, and was not altered by cleaning, as L sometimes scrubbed until bleeding. L felt that people sneeze or cough in L's presence because they are aware of the smell.
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13	<p data-bbox="367 956 391 990"><i>M</i></p> <ul data-bbox="414 1012 1300 1400" style="list-style-type: none"> <li data-bbox="414 1012 1300 1079">• M expressed one main difficulty, which was the persistent voices that accuse M of either being 'bent' or 'backwards'. <li data-bbox="414 1102 1300 1258">• <i>M reports overhearing the conversations of neighbours and was convinced that they were discussing M, suggesting that M was gay and backwards. M stated themselves to be a 'clever and intelligent person' and not interested in same sex relationships.</i> <li data-bbox="414 1281 1300 1400">• M reported being very concerned about the safety of the flat in which M lived, and worried that the people that run the flat are too interested in M and what M wears. In addition M would hide from the people who M felt were talking about M, or look to find the source of the voices. <p data-bbox="367 1422 1300 1579">M's beliefs about people saying M is gay and backwards has persisted throughout M's life, although M has tried to move homes to escape from the neighbours. At the time of interview M felt the voices came particularly from a young couple downstairs who would tell their friends about M. M felt strongly that the voices were real, despite their persistence throughout different living situations.</p>
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19	<p data-bbox="304 383 320 405">S</p> <ul data-bbox="352 443 1225 887" style="list-style-type: none"> <li data-bbox="352 443 1225 618">• S reported a history of paranoia throughout their life and experiences of losing reality at times. S described a belief in the past of being a member of a “Program”. This organisation took S under their wing and developed young people who had experienced difficulties. The ‘program’ aimed to provide S with help and support. S reported that this “program” was flawed, because it became threatening towards S, insulting S when S acted independently. <li data-bbox="352 651 1225 712">• During this time S reported that S’s will had been ‘subjugated’ to that of the program, and all S’s behaviour was directed by them. <li data-bbox="352 745 1225 887">• S felt that the membership of the “program” involved being monitored by the “conspirators” who were a governmental organisation who did not approve of the “program” and monitored its members. S reported feeling that buildings were bugged to monitor S, and that medical staff were signed up to the “program” <p data-bbox="304 920 1225 976">At the time of interview S reported considerable insight into these delusional beliefs and was able to recognise the fluctuations in beliefs and conviction in them.</p>
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15	<p data-bbox="304 1043 320 1066">O</p> <p data-bbox="304 1104 1225 1160">At interview O reported a number of different beliefs when unwell, which O felt were interconnected.</p> <ul data-bbox="352 1171 1225 1641" style="list-style-type: none"> <li data-bbox="352 1171 1225 1249">• When talking to people O felt that they were clones, not O’s family, that they were disguised in masks, and felt not able to trust people. O reports feeling real in themselves, but was a special person <li data-bbox="352 1261 1225 1317">• There were people who were out to get O, who had some connections to angels and devils. <li data-bbox="352 1328 1225 1406">• Thought whole family was dying, evil had infected them with AIDS, lights were changing and family were all drifting off to heaven. O felt like was infested with insects, and tumours in body, everything was evil and poisonous. <li data-bbox="352 1417 1225 1473">• That people were trying to bring O’s family down, they would kill O and lay the blame on the family, or they were monitoring to catch any criminal activity <li data-bbox="352 1485 1225 1563">• also reported an obsession with angel presences and bad spirits, and became obsessed that the local Greek church was sending devil spirits against O and O’s family. <li data-bbox="352 1574 1225 1641">• Conspiracy – sister’s friends, people wanting to target and send to prison everyone O knew, they had been gathering evidence for years and years and would send family down. <p data-bbox="304 1675 1225 1843">O reported a number of anomalous experiences which had provided the evidence for these beliefs, including seeing little cameras in the lights in O’s room, everything seemed brighter, not really feeling there, feeling disorientated and strange and occasionally heard a voice that said O was a paedophoile. At times O reported being concerned about hypnotism, and as a result was unable to look into people’s eyes when in psychiatric hospital.</p>
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Schemas Vignettes sent to Panel

6	<p><i>Participant six highly endorsed the following schemas:</i></p> <p>Mistrust/Abuse</p> <p>Social Isolation</p> <p>Dependence/Incompetence</p> <p><i>Subjugation</i></p>
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7	<p><i>Participant 7 highly endorsed the following schemas:</i></p> <p>Emotional Deprivation</p>
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8	<p>Participant 8 highly endorsed the following schemas:</p> <p>Emotional Deprivation</p> <p>Vulnerability/Harm</p> <p>Self-sacrifice</p>
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12	<p><i>Participant 12 did not score above 75% on any schema. The highest two schemas are described below:</i></p> <p>Emotional Deprivation</p> <p>Social Isolation</p>
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13	<p><i>Participant 13 highly endorsed the following schemas</i></p> <p>Mistrust/Abuse</p> <p>Self-sacrifice</p> <p>Unrelenting standards</p>
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14	<p><i>Participant 14 highly endorsed the following schemas:</i></p> <p>Emotional Deprivation</p> <p>Mistrust/abuse</p> <p>Social Isolation</p> <p>Defectiveness/Shame</p> <p>Dependence/Incompetence</p> <p>Subjugation</p>
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16	<p><i>Participant 16 highly endorsed the following schemas:</i></p> <p>Abandonment</p> <p>Defectiveness/Shame</p> <p>Failure</p> <p>Vulnerability/Harm</p> <p>Subjugation</p> <p>Insufficient Self-control/self-discipline</p>
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18	<p><i>Participant 18 highly endorsed the following schemas:</i></p> <p>Emotional Deprivation</p> <p>Social Isolation</p> <p>Vulnerability/Harm</p> <p>Mistrust/Abuse</p> <p>Subjugation</p> <p>Unrelenting standards</p> <p>Insufficient Self-control/Self-discipline</p>
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Early experience vignettes sent to panel to match to schema and delusion vignettes

3	<p>Background information</p> <p>B is a 46 year old man who was fostered as a young child. He had worked in the merchant navy and in the building and engineering industry. He experience his first breakdown in 1978 although he did not receive treatment at this time. and was subsequently well until 1991 when he was admitted to hospital.</p> <p>Abuse History</p> <p>B's CTQ scores noted a severe level of abuse on physical and emotional abuse as well as severe emotional and physical neglect. When completing the CTQ, B included an experience of adult sexual molestation, which is beyond the focus of this study. Without this adult abuse, B scores within the low range for sexual abuse.</p> <p>B was placed in foster care due to difficult circumstances at home. He believes that he and his siblings were being "severely physically and sexually abused" although he does not have a recollection of this being too young at the time. B was placed in a children's home until the age of five, where he felt he thrived, before his placement with foster parents.</p> <p>B reported experiencing physical, mental and verbal abuse at the hands of both his foster parents until he left home, and his brother and sister experienced similar treatment. B reported not being able to disclose this to authorities at the time since they were "very closely controlled".</p> <p>B feels much confusion about what happened to him as a baby. He was suspicious that there may have been sexual abuse at the hands of his natural parents or their friends. However he also reported that he was unsure as he felt his recollections were "riddled with delusion".</p>
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6	<p>Background information</p> <p>E is a 42 yr old, white British, single woman with 3 children. She left school at age 16 before taking any exams. She has done various jobs in the past including supermarket work, hairdressing, pub work, but has not worked for the past 7 years. She has been diagnosed in the past with depression with psychotic features and obsessive compulsive disorder. Her first admission was in 1997 and she had several subsequent admissions, the last of which was about 5 years ago.</p> <p>Abuse History</p> <p>E's CTQ scores indicated a severe level of emotional and sexual abuse, in addition to emotional and physical neglect which were also in the severe range. E did not report any physical abuse.</p> <p>E was sexually abused by both her father and her mother's boyfriend between the ages of 8 and 15 years. This occurred on a weekly basis and involved touching but not full sexual intercourse.</p>
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7	<p><i>Background information</i></p> <p>K is a 42 year old man. He is currently in a relationship and is unemployed. K has a history of depression in addition to a number of psychotic symptoms. He has not been admitted into hospital, although there have been times when it has been suggested by his care team.</p> <p><i>Abuse History</i></p> <p>K's CTQ indicated emotional and physical abuse in the severe range.</p> <p>K reported very different parenting experiences between his mother and father. K describes feeling that his father was loving and supportive. However he felt his mother wished he had not been born, and witnessed his mother being violent towards his father as he was growing up. K was physically abuse by his mother, who would beat him with a broom handle, this was frequently in response to him wetting the bed through to his teenage years. His mother had a number of admissions to psychiatric hospital whilst K was young.</p> <p>K reports clear dissociative experiences during the abuse, feeling that he was outside of his body. K also reported that at times he felt his genitals did not belong to his body as a child.</p>
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10	<p><i>Background History</i></p> <p>M is a 37 year old single, Afro-Caribbean woman. She left school at age 15 before taking O-levels. She is not currently employed but in the past has worked in catering and as a care assistant. She has had two psychiatric admissions: one in 2002 and she is currently an inpatient.</p> <p><i>Abuse History</i></p> <p>M's CTQ scores indicated emotional and physical abuse on the severe range. In addition her score on the physical neglect scale was in the moderate range.</p> <p>M was often hit so hard that it left bruises and was punished with a belt. She was often hit so badly that it was noticed by other people.</p>
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11	<p><i>Background information</i></p> <p>F is a 23 yr old female university student. She had been diagnosed with schizophrenia 3 years ago following her first admission to psychiatric care, but at the time of interview was medication free.</p> <p><i>Abuse History</i></p> <p>F's CTQ scores indicated emotional abuse in the severe range. She did not report physical or sexual abuse, or neglect.</p> <p>F reported severe emotional abuse particularly by her father during her childhood, who would talk openly about her in an extremely negative manner. Their relationship was very difficult and her father suffered from bipolar disorder and she described him as a 'strange man'.</p>
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12	<p>Background information</p> <p>P is a 60 year old man. He is single and is currently retired. In the past he was employed as a machinist. P has a history of psychosis with at least five admissions for psychiatric care.</p> <p>Abuse History</p> <p>P's CTQ scores indicated emotional and physical abuse in the severe range and emotional neglect also fell into the severe category. P also scored in the moderate range for physical neglect.</p> <p>P was born into a large family and was raised by his mother after his father walked out. P was punished severely by his mother for any wrong doing, he would be beaten with objects (frequently with shoes). P saw this as his mother's revenge for P having driven his father away and because he wet the bed. P's other siblings were not punished in the same way.</p>
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16	<p>Background information</p> <p>S is a 32 year old woman who was currently unemployed. She reported multiple short term jobs in her past. S was first admitted to psychiatric care 5 years ago and reports 5 or 6 admissions since this time. S reported a history of self harm as a teenager.</p> <p>Abuse History</p> <p>S scores on the CTQ placed her in the severe range for emotional abuse. She did not report any physical or sexual abuse, or neglect.</p> <p>S reported a history of emotional abuse within her family, being teased by her parents and siblings from the age of ten through to the present day. She reports this teasing happening when she was feeling vulnerable, and also reports being bullied at school due to her eczema. S reported that she self harmed as a teenager due to the teasing by her family and friends, but this was criticised as being "attention seeking" by her parents.</p>
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18	<p>Background History</p> <p>N is a 37 year old woman who was unemployed at the time of interview. N reported an 8 year history of psychotic difficulties starting after the birth of her first child. At the time of interview N had two children, aged 5 and 8.</p> <p>Abuse History</p> <p>N's CTQ scores placed her in the severe range for both emotional abuse and physical neglect. She did not report physical or sexual abuse.</p> <p>N was reluctant to discuss her experiences at interview although she consented for the researcher to consult the notes of a recent assessment interview. This revealed the experience of emotional abuse from in the home, having a difficult relationship with her father. Although N did not score in the severe or moderate range for sexual abuse, she reported a confusing memory of lying on the bed with her father, and is concerned that there may have been something sexual happening which she is not able to remember.</p>
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