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WOMEN'S EXPERIENCES OF CHILDHOOD SEXUAL ABUSE AND PSYCHOSIS IN ADULTHOOD

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The Therapeutic Alliance and Client Change in Cognitive- Behaviour and Psychodynamic Therapies

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Introduction

Many attempts to evaluate therapeutic practice and its links to psychological theory have tended to focus on psychotherapy's instrumental effectiveness compared with, for example, psychopharmacological treatments. Attempts to distil the active therapeutic ingredients have aimed at the use of randomised and controlled trial methodologies in combination with the Diagnostic and Statistical Manual's (e.g. DSM IV) categorisation of psychopathology. Roth and Fonagy's landmark "What Works for whom" (Roth & Fonagy, 1998) helped establish a clear legitimacy for the practice of psychotherapy on the basis of empirically supported interventions. Some recent criticisms of the literature[i] however, have called for a greater emphasis on therapeutic relationships, in addition to technical interventions, to deepen understanding of client change within psychotherapy (Norcross, 2002).

The UK Department of Health (2001) in outlining its guidelines for appropriate choice of psychotherapeutic treatment states "effectiveness of all types of therapy depends on the patient and the therapist forming a good working relationship" (DOH, 2001, p35). However Norcross (2002, p5) points out that "no evidence-based guidance is offered on which therapist behaviours contribute to or cultivate that relationship." Horvath (1994) discussed how the relationship between the therapist and the client can be understood either as a trait-like phenomenon, reflecting the overall quality of therapy, or as a process phenomenon reflecting its moment-by-moment quality. A new (or rather renewed) focus on interpersonal processes in addition to existing intervention research may therefore herald a greater understanding of psychotherapeutic effectiveness.

This essay examines the therapeutic alliance, and how processes involved in its unfolding can help to promote client change. Current literature on the importance of the therapeutic alliance will be reviewed. Two treatment models, Cognitive and Psychodynamic therapies will then be examined. These two therapeutic models differ in their conceptualisations of the therapeutic alliance and some of these key differences will be examined along with some similarities. Treatment of Borderline Personality Disorder (BPD) provides an interesting focal point for this discussion because this client group has often been considered as hard to engage (Fonagy, 2004). In response to the interpersonal difficulties of working with this client group both Cognitive and Psychodynamic theories have converged through re-examination of the therapeutic alliance (Milton 2001). In conclusion, the similarities of these approaches and the value of developing one's own thinking about therapeutic alliances, regardless of theoretical orientation is considered from my own viewpoint as a trainee clinical psychologist.

What is the Therapeutic Alliance?

Psychotherapy can be seen as a socially sanctioned, formalised, interpersonal endeavour, distinct from yet similar to other meaningful human relationships. From an empiricist standpoint therapy can be seen in terms of theoretically driven interventions made by the therapist or scientist-practitioner and given to the patient to reduce symptoms (Marzillier & Hall 1999). Alternatively, a constructivist position might hold that a psychotherapist relates to the client so that s/he can develop new ways to construct meaning through self-change (Guillem, 2004).

The therapeutic alliance itself, has been defined as the attachment and collaboration between the client and therapist (Bordin, 1979) or “the feelings and attitudes that counseling participants have toward one another, and the manner in which these are expressed” (Gelso, 1994). Hatcher & Barends (1996) described the relationship as having a tripartite structure. Firstly, there are Tasks. These are undertaken by both parties in therapy; crucially these must be strongly valued by client and therapist alike. Secondly, there are bonds. These are positive interpersonal and emotional attachments including, trust, acceptance and confidence. Thirdly, there are goals. These are the objectives that therapy should achieve and which should be mutually agreed upon (Hatcher & Barends, 1996).

An important function of any definition would also be to clarify what a concept is not. For example, the therapeutic alliance is not a friendship and is not bound by reciprocity of emotion in the same way. Neither party is required to like one another, merely to develop a working rapport. There is also often no pretence of equality of information between participants and it is often acknowledged there is a consistent power imbalance in therapeutic relationships (Shahar, 2004).

The Therapeutic Alliance- current literature

An Ovid (Psycinfo 1872-2005) title word search of ‘Therapeutic Alliance’ for this essay (January 2005) showed four hundred and thirty five citations in total. The first dating from 1962. There were sixty citations for the period 1980-1989. Two hundred and twenty two for the period 1990-1999. Lastly there were one hundred and twenty five citations for the first four years of the 21st Century. This is only one search category but does hint to an increase in interest in the therapeutic alliance. It may also reflect a shift of emphasis in the way cognitively based theories understand the therapeutic alliance, as well as renewed vigour from within psychodynamic orientations (Milton 2001).

Lambert et al. (2002) in his review of the research literature, points to the following breakdown of factors involved in client change during psychotherapy. Around 15% of the change is attributable to placebo or expectancy factors. Some 40% due to “extratherapeutic change” or factors outside of the therapeutic setting. Around 15% of the client change was attributable to technical interventions of the therapists and around 30% attributable to common factors of the therapeutic process, i.e. the therapeutic alliance (Lambert et. al. in Norcross 2002 p17). These broad figures point towards the need to increase attention on the role of the therapeutic alliance.

The American Psychological Association’s “Division 29 Task force on Empirically Supported Relationships” provided a comprehensive review of the literature on “effective therapy relationships.” The Division 29 (Norcross, 2002; p7) chose to focus on certain factors within the therapeutic relationship. These included some of the Rogerian “core conditions of empathy, positive regard, genuineness or congruence (Rogers, 1957). They also focused on self-disclosure and relational interpretations (Norcross, 2002; p8). Not included were: confrontation, credibility and provision of explanation or rationale of therapy (Norcross, 2002; p10). This would exclude examination of some key factors of both cognitive and psychodynamic approaches to therapy as we will see later.

The ‘Task Force 29’ made several conclusions in relation to empirically supported relationships. Principally they were to move the research agenda towards an inclusion of relationship variables in addition to, not at the expense of, outcome studies of technical therapeutic interventions (Norcross, 2002, p441).[ii] Their recommendations for the further practice of psychotherapy were to create and cultivate therapeutic relations and to adapt therapy relationship to client characteristics combining empirically supported relationships with empirically supported treatments tailored to the patient's disorder and characteristics (Norcross, 2002 p442).

What makes a good Therapeutic Alliance?

Lambert & Barley (Norcross, 2002; p26) four major conclusions from their review of the past sixty years of outcome research on psychotherapy were: 1. Psychotherapy is successful in general. The average treated client is better off than 4 out of 5 (80%) of untreated subjects, 2. Techniques are consistently reported as equivalent, 3. Measures of the quality of therapeutic alliance correlate strongly with client outcome, particularly so when clients rate the therapeutic relationship. 4. Clients report that better therapists are generally: more accepting, understanding, empathic, warm and supportive, and engage in less negative behaviours like blaming, ignoring or rejecting.

For therapists to be effective in promoting client change they must therefore pay attention to the kind of relationship they need to foster with the client. The therapist has a great responsibility to the client in this respect. It also essential that they take care of themselves as therapists and as people so that they are able to offer clients such empathy, warmth and support on a consistent basis (Kottler, 1993). From this perspective it becomes a professional duty for the therapist to minimise interference in his/her ability to relate to clients.

This consistency in the face of myriad daily influences on the therapist as person and as a professional points to the question: does training and experience increase therapist reliability? Norcross (2002, p13) points out that “expert therapists appeared to be less handicapped by their own “bad moods” than were their less skilled peers…The research on the therapist’s level of experience suggests that experience begets heightened attention to the client (less-self preoccupation), an innovative perspective, and in general, more endorsement of an “eclectic” orientation predicated on client need.” If this is so, trainee clinical psychologists must arguably pay more attention to how they look after themselves. Their awareness of interacting personal and professional issues can also focus on developing therapeutic consistency as a tool in itself, for creating and maintaining good therapeutic alliances.

The Therapeutic Alliance in Psychodynamic Therapy

One of the cornerstones of Psychodynamic theory has been the concepts of transference and counter-transference. These concepts now pervade a wide territory outside of psychodynamic practice (Roper, 2003; Salzberger-Wittenberg, 1970). The original concept from Freud (1895) arose when he began to realise clinically that his patients were somehow bringing previous ways of relating to others into the therapeutic relationship. These transferences of emotion affected the therapist’s perception of the client, his/her interpretation of new therapeutic situations and influenced his/her behaviour accordingly (Salzberger-Wittenberg, 1970).

Counter-transference is considered the inappropriate transfer of thoughts or feelings from the therapist to the client. This may reflect previous life issues the therapist has not yet addressed. A further aspect of counter-transference relates to the feelings experienced by the therapist in response to the client's transference (Salzberger-Wittenberg, 1970). The development of these concepts has necessitated (within psychoanalytic approaches) the consideration of the therapist's personal history as relevant to the therapeutic alliance. In that, inappropriate responding to client's transference may at best result in missing opportunities to further therapy and at worst produce greater harm to the relationship and/or the client. Therefore developing an awareness of self (through analysis) increases the therapist's ability to spot client transference in the first place and monitor his/her own counter-transference (Milton, 2001).

In both transference and counter-transference, expectations are central. It is argued that clients experience emotions regarding the therapists that the therapists did not intend. In addition, clients often try to distort their therapists in line with these expectations while simultaneously altering their own behavior and feelings to conform to them. At the root of both transference and counter-transference is not only this transferential relationship, but also by definition an alternate "real relationship." The goal of therapy being to minimize the former and maximize the latter (Gelso, 1994).

The psychodynamic approaches then, demand the systematic working through of ones own "demons" as well as those of clients. This should render the therapist more aware- i.e. bring more into consciousness ones own desires/dislikes and unresolved issues. Horvarth and Bedi (Horvath & Bedi, 2002) suggest along with Strupp (Strupp, 1998) that unresolved personal issues in the therapist may be a significant limiting factor in therapeutic potential.

The deeply embedded nature of these concepts in psychodynamic thought provides a fundamentally different approach to therapy than in CBT. Here the relationship becomes the work in itself, and the therapist's role becomes that of sign-posting or confronting issues of transference and their blocks to therapeutic progress (Joseph, 1986). Both the client and the therapist bring their previous histories and present expectations which combine in the therapeutic alliance minute by minute. One does of course have to accept the concept of transference first. Have there been any empirical studies of these psychodynamic processes within the therapeutic alliance?

In a study comparing therapeutic alliances in cognitive-behavioural and psychodynamic approaches using the same therapists for both, CBT came out better in terms of the quality of the alliance, as rated by clients. However, in their discussion of these results Raue and his colleagues noted that the shortened nature of the psychodynamic treatment produced less time addressing therapy relationship issues (Raue, 1997). In this study the mean number of sessions for the psychodynamic group was nine (an extremely small number of sessions for this approach) as opposed to 26 in a previous study by the same author (Raue et al. 1993). Relationship themes may not have occurred as often or as intensely with this kind of short, manualised psychodynamic model, compared with ongoing naturalistic therapy (Raue, 1997). Also, when negative client reactions to the therapist or therapy came up such as mistrust or disillusionment in therapy, they were often attended to for only relatively short periods. They were then usually linked to other related areas in the clients' lives, or occasionally redirected to a new topic area (Raue, 1997). Another limitation in more short-term dynamic therapies may be that the therapists are not able to adequately elicit client transferences for interpretation.(Connolly, 2000)

These constraints echo Milton's (2001) critique of the empirical evidence, highlighting the limitations of comparing CBT which has a typically short duration with a shortened version of psychoanalysis which would "ordinarily demand five sessions a week over a period of years" (Milton, 2001, p443).

In her discussion of Kleinian approaches to therapeutic relationships, Salzberger-Wittenberg (1970) discusses a further concept of holding or containment. The description of this concept links to notions of empathy and of being empathic (Rogers, 1957). The described quality is that of being able to listen actively, to be present within the interaction, and to not be phased or shocked by the client's disclosures. Not being afraid to fully listen to the client can give him/her hope that the situation can be tolerated or modulated, Salzberger-Wittenberg (1970). The notion of containment also links closely to that of transference in that the client is able to project as much of her negative transferences into the therapeutic relationship if s/he somehow knows the therapist can contain them (Milton, 2001).

Milton (2001) sees the therapist as often relating to the client as a participant observer (p435) particularly in a phase of free association. It is interesting to note that Milton (2001) describes different relationship phases within the therapeutic alliance echoing Prochaska's (2002) thinking on relationship stages. She describes the transferential relationship as outlined above, but also that a psychoanalyst may deliberately adopt a more 'cognitive' style after a period of intense transference interpretation (Milton, 2001, p430). At other times, the psychoanalyst may "reason with their patients, explain to them, make practical suggestions, and so on" (p430). This suggests a more flexible approach in relating to clients than a stereotypical conception of psychodynamic therapy.

A possible limitation of the psychodynamic approach concerns the assumed applicability of the therapy to particular kinds of clients. Fonagy (1998) writes "a history of psychotic breakdown, severe obsessional states, somatization, and a lack of frustration tolerance are normally regarded as contra-indications" (Fonagy, 1998, p109). This limited and subjective set of criteria allude to a reluctance to work with clients who may be harder to engage than a particular ideal client. Milton (2001) in her critique of CBT states that psychodynamic approaches are more confrontational and less constrained by the need to maintain a supportive stance towards the client (Milton, 2001). This more distant and/or confrontational style may have implications for initiating work with harder to engage clients where an already high drop-out rate from therapy becomes a key concern.

The Therapeutic Alliance in Cognitive-Behaviour Therapy

CBT is characterized by an active and directive therapeutic stance and high levels of emotional support (Keijsers, 2000). The effectiveness of Cognitive-Behaviour therapy (CBT) has been predicted by the quality of the therapeutic alliance and client emotional involvement in therapy (Castonguay, 1996). CBT has shown significantly greater alliance scores than for psychodynamic approaches (Raue, 1997). This points to differences in the two approaches and demonstrates the early emphasis placed on supportive and empathic relating in CBT. This is in line with other studies demonstrating greater alliances (Raue et al., 1993), a greater degree of empathy, congruence, and interpersonal contact (Sloane, 1975) and high use of non-possessive warmth, positive regard, and genuineness for CBT (Keijsers, 2000).

As pointed out above, the comparative methodologies of some of these studies do favour the inherently shorter structure of cognitive based therapies. Additionally, Overholser (1998) emphasized the importance of the therapeutic alliance in cognitive-behavioural therapy for depression but not at the expense of the structure of the therapeutic endeavour. Over-reliance on building and maintaining the relationship alone might divert attention from the clarity and progress provided by a structured process (Overholser, 1998).

In CBT then, the therapeutic alliance is not so much the therapy itself, but the conduit through which therapeutic interventions are delivered. Overholser (1998) maintained that the cognitive-behavioural therapist should strive towards seven different goals in developing and maintaining a therapeutic alliance; 1. create a trusting and open environment, 2. display hope that the client can change, 3. respond empathically to client distress, 4. remain calm and objective, 5. emphasise collaboration, 6. remain adaptive and creative, 7. apply in-session work to clients life outside of therapy (Overholser, 1998, p1).

Milton (2001) sites Weishaar's (1993) biography of Aaron T. Beck who notes "Beck's treatment manual fails to capture the heart of his own empathic therapeutic style, as seen on videotapes" (Milton, 2001, p434). This points to the balance CBT practitioners must strike between appropriate techniques and structure on the one hand and relating to the client on the other. Cognitive-behavioural approaches have been found to be most useful for clients relatively low in resistance traits and who are self-directed (Beutler, 2002).

One important strand in cognitive therapy relating to client change is Prochaska and Di Clemente's stages of change model (Prochaska & DiClemente, 1992). This model breaks down a clients way of relating to an identified problem into five areas. Firstly, a client may be pre-contemplative or not ready to think about change. Then a client may move to a contemplative stage, where thinking about change occurs without concrete action being taken. A client may then move towards a preparation and then an action stage where changes in behaviour relating to the problem may occur. Finally, a client may enter a maintenance phase, where change is consolidated. Crucially, relapse may occur in this process and move a client back to any of these stages. It may be argued that this is merely a formalised version of what therapists knew already. However, it's utility lies in enabling the therapist to see where the client is in relation to change itself. The therapist in assessing which stage the client currently mainly resides in, can decide whether to be exploratory with the client or more action focused. Also, it minimises the therapist frustration at pushing the client to change when the client is not yet thinking in those terms. This approach minimises confrontation and friction in the therapeutic alliance with the therapist staying client focused and non-judgemental.

Building on his previous work on client readiness to change Prochaska describes fitting the relationship stance to the type of client and his/her readiness to change. This is as follows: For a pre-contemplator, the therapist's role becomes like a 'nurturing parent' developing the therapeutic bond. In contemplation, the therapist becomes a Socratic questioner, helping to raise consciousness in the client through exploration. In the preparation stage, the client is like an experienced coach with key knowledge and experience for how implement plans. In action, maintenance and the therapist will take on a consultative role providing expert advice. In relapse, collaborative plans already made will interact with where the client then moves back to in the stage cycle (Prochaska & Norcross, 2002) .

Cognitive-Behaviour and Psychodynamic Therapeutic Alliances in Borderline Personality Disorder

Borderline personality disorder (BPD) as defined by DSM IV describes a persistent pattern of functioning that includes; unstable and intense relationships, impulsivity, affective instability, anger, suicidal or self-harming activity, identity disturbance and feelings of emptiness or aloneness (Gunderson, 2001). Regardless of ones concerns over the validity of this diagnostic category, the characteristics of this syndrome of behaviours can be viewed as problematic to engage and treat. Gunderson (2001) notes "the diagnosis of BPD [as opposed to an Axis 1 disorder] means that emotional involvement will be an essential aspect of meaningful treatment" (p44).

Both psychodynamic therapy and cognitive behavior therapy can effectively treat BPD, with some evidence pointing to larger effect sizes for psychodynamic treatment outcomes (Leichsenring, 2003). However, many modifications have been made to the original therapeutic orientations, such that new therapies, such as Dialectical Behaviour Therapy, or Cognitive Analytic Therapy have emerged (Bateman, 2004).

The "hard to engage" characteristics of this client group heightens the need to develop good working alliances between therapist and client. Additionally, approaches to working with BPD emphasise other aspects of the therapeutic relationship, such as, setting out clear contracts, boundaries and plans with the client (Gunderson, 2001).

Cognitive therapy's increased emphasis on the therapeutic relationship has been described as a "relationship laboratory" (Bateman, 2004). This laboratory is essentially a safe space where clients are socialised to a cognitive model and taught new skills and techniques in relating to others. This supportive and reality-oriented approach aims at gradual social adjustment in the context of a realistic therapeutic relationship. The therapist takes on many relationship roles (echoing Prochaska's relationship stages) in order to facilitate practice in ways of relating for the client.

Psychodynamic thinking has moved towards increased structure and a contractual approach; away from its traditionally more free-associative stance. The hateful and destructive feelings that arise because of transference are eventually replaced by the client with more constructive and positive reactions with the help of therapist interpretations. Gunderson, a psychodynamically oriented psychiatrist, notes his approach, to be tightly focused on and interpretative or exploratory with patient behaviours in session (Gunderson, 2001). At the same time, the more confrontational and interpretative stance of psychoanalysis has had to alter in the face of poor patient engagement and drop-out rates as high as 50% (Aronson, 1989).

The mentalization based treatment of Fonagy and Bateman (2004) draws from both cognitive and dynamic paradigms, particularly the latter. The "mentalizing stance" of the therapist is geared towards fostering more meta-cognitive processes in the client;

> **The crux of the value of psychotherapy with BPD is the experience of other human minds having the patient's mind in mind…The explicit content of interpreting or**

> **educating is merely the vehicle for the implicit process that has therapeutic value. (Bateman, 2004)p141)**

Within the therapeutic dyad, the therapist must allow for counter-transference to take place and not berate him/herself for responding to the client in uncharacteristic ways, such as angry, over-familiarity or critical. The goal is for the therapist to make clear and explicit his perception of the interaction with the client without colonising or invading the client's emotions and without being colonised or invaded him/herself. Interestingly, Bateman and Fonagy also look outside of the therapeutic dyad, and encourage examination of as many interpersonal encounters with services, including administration staff etc. the client may have. This is seen as more data from which to understand a clients thematic interpersonal relating and opens out the therapeutic relationship to encompass a client's relating to an entire service (Bateman & Fonagy 2004).

Conclusions

This essay has tried to underline the importance of the therapeutic alliance in general and in psychodynamic and cognitive-behavioural approaches in particular. The radical interpretative stance of psychodynamic therapy emphasises relationship with the client as raw material for a process that may or may not be confrontational by dint of therapist neutrality. From this perspective, non-confrontational work such as CBT often lacks the bite needed for real insight to be developed by the client (Milton, 2001). On the CBT side of the fence a more pragmatic and evidence based approach has questioned the utility in confronting clients. Here a warm, empathic and supportive therapeutic stance provides the bridge over which the client can reach a deeper understanding of him/herself and incorporate a more balanced view of themselves (Hall, 1999).

The increasing willingness of professionals to work with Borderline personality disorder has resulted in a renewed emphasis on the therapeutic relationship in the face of a client group defined by their instability in relating interpersonally. Work in this domain draws on both cognitive and dynamic traditions. Specifically, from the dynamic tradition, work with borderline clients is understood to be of a longer duration compared to classical CBT and may needs therapist supervision (Gunderson, 2001). From cognitive thinking, a supportive and structured focus helps in developing a working alliance early in treatment lessening premature termination of therapy. Especially given that drop out rates for this client group are so high (Aronson, 1989).

In my training I ask myself at least these following questions. What is the real work of psychotherapy? Is it implementing a particular technique I have been practicing or discussing in supervision or the act of relating to the client in and of itself. Is it reflecting on the relation, noting ones agreeableness to the client, the amount they bore, excite, repulse, attract or confuse me? Adjusting oneself to this knowledge, choosing what to show of myself, maintaining awareness of what to keep back in the interest of the client? Judging what is in the interest of the client? Mirroring the client's behaviour, speech style, content and non-verbal behaviour? Making explicit what is implicit, reading between the lines and asking the questions that must be asked? Showing that I can withstand the most shocking piece of news and that I will not judge, be amazed, shocked or disappointed? Giving the client the time to be silent or to talk, showing my interest and commitment?

For those entering clinical psychology training, such as myself, the dizzying array of therapeutic techniques can be contextualised by considering the therapeutic alliance as a common thread running through each orientation. Research has begun to provide answers to many of these questions.

References

Aronson, T. (1989). A critical review of psychotherapeutic treatments of the borderline personality: Historical trends and future directions. *Journal of Nervous and Mental Disease, 177, 511-528.*

Bateman, A. Fonagy, P. (2004). *Psychotherapy for Borderline Personality Disorder* (First ed.). Oxford: Oxford University Press.

Beutler, L. E., Moleiro, C.M, Talebi, H. (2002). Resistence. In J. C. Norcross (Ed.), *Psychotherapy Relationships that Work (Therapist contributions and responsiveness to patients.* (pp. p129). New York: Oxford University Press.

Bordin, E. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy, 16, 252-260.*

Castonguay, L. G., Goldfried, M.R., Wiser, S., Raue, P., Hayes, A.M. (1996). Predicting the Effect of Cognitive Therapy for Depression: A Study of Unique and Common Factors. *Journal of Consulting and Clinical Psychology, 64, 497-504.*

Connolly, M. B., Crits-Christoph, P., Barber, J.P., Luborsky, L. (2000). Transference Patterns in the Therapeutic Relationship in Supportive-Expressive Psychotherapy for Depression. *Psychotherapy Research, 10, 356-372.*

Fonagy, P. (1998). Technical Issues in Psychodynamic Therapy. In *Comprehensive Clinical Psychology, 6, 109.*

Fonagy, P. Roth., A. (1998). *What Works for Whom?: A critical review of psychotherapy* research. London: Guildford Press.

Gelso, C. J. Carter., J.A. (1994). Components of the psychotherapy relationship: their interaction and unfolding during treatment. *Journal of Counseling Psychology, 41, 296-306.*

Guillem, F. Bottella., L. (2004). Psychotherapy Integration: Reflections and Contributions From a Constructivist Epistemology. *Journal of Psychotherapy Integration, 14, 192-222.*

Gunderson, J. G. (2001). *Borderline Personality Disorder-A Clinical Guide* (First ed.). Washington DC: American Psychiatric Publishing Incorporated.

Hall, J. Marzillier, J. (1999). *What is Clinical Psychology?* (Third ed.). Oxford: Oxford University Press.

Hatcher, R. L. Barends, A.W. (1996). Patients' View of the Alliance in Psychotherapy: Exploratory Factor Analysis of Three Alliance Measures. *Journal of Consulting and Clinical Psychology, 64, 1326-1336.*

Horvath, A. O., Bedi-Robinder, P. (2002). The Alliance. In J. C. Norcross (Ed.), *Psychotherapeutic Relationships That Work: Therapist Contributions and Responsiveness to Patients* (First ed., pp. 37-69). London: Oxford University Press.

Joseph, B. (1986). Transference: The total situation. *International Journal of Psychoanalysis, 66, 447-454.*

Keijsers, G. P. J., Schaap, C.P.D.R., Hoogduin, C.A.L. (2000). The Impact of Interpersonal Patient and Therapist Behaviour on Outcome in Cognitive-Behavioural *Therapy. Behavior Modification, 24, 264-297.*

Kottler, J. A. (1993). *On Being a Therapist* (Revised ed.). San Francisco: Jossey-Bass Inc.

Leichsenring, F. Leibing., E. (2003). The Effectiveness of Psychodynamic Therapy and Cognitive Behaviour Therapy in the Treatment of Personality Disorders: A Meta-Analysis. *American Journal of Psychiatry, 160, 1223-1232.*

Milton, J. (2001). Psychoanalysis and Cognitive Behaviour Therapy-Rival Paradigms or Common Ground? *International Journal of Psychoanalysis, 82, 431.*

Norcross, J.C. Ed. (2002) *Psychotherapy Relationships That Work: Therapist Contributions and Responsiveness to Patients*. Oxford University Press.

Overholser, J. C., & Eden, J.S. (1998). Cognitive-Behavioural Treatment of Depression, Part VIII. Developing and Utilizing the Therapeutic Relationship. *Journal of Contemporary Psychotheray, 28.*

Prochaska, J. O., & Norcross, J.C. (2002). Stages of Change. In First (Ed.), *Psychotherapy Relationships that Work: Therapist Contributions and Responsiveness to Patients* (pp. 303-313). London: Oxford University Press.

Prochaska, J. O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47, 1102-1114.*

Raue, P. J. Goldfried., M. R; Barkham, M. (1997). The Therapeutic Alliance in Psychodynamic–Interpersonal and Cognitive–Behavioral Therapy. *Journal of Consulting and Clinical Psychology, 65, 582-587.*

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting and Clinical Psychology, 21, 95-103.*

Roper, M. (2003). Analysing The Analysed: Transference and Counter-Transference In The Oral History Encounter. *The Journal of the Oral History Society, 31, Abstracts.*

Salzberger-Wittenberg, I. (1970). *Psycho-Analytic Insight and Relationships: A Kleinian Approach* (First ed.). London: Routledge & Kegan Paul.

Shahar, G. (2004). Transference-Countertransference:Where the (Political) Action is. *Journal of Psychotherapy Integration, 14, 371-396.*

Sloane, R. B. e. a. (1975). Short-term Analytical Oriented Psychotherapy versus Behaviour Therapy. *American Journal of Psychiatry, 132, 373-377.*

Strupp, H. H. (1998). The Vanderbilt Study I revisited. *Psychotherapy Research, 8, 17-29.*

Department of Health Publications, (2001). *Treatment choice in psychological therapies and counselling: Evidence based practice guidelines. London.*

Michael J. Lambert, Dean E. Barley. Ch2, p 17 The Alliance. In J. C. Norcross (Ed.), *Psychotherapeutic Relationships That Work (2002): Therapist Contributions and Responsiveness to Patients* (First ed., pp. 37-69). London: Oxford University Press.

Politically and Ethically Motivated Psychotherapy.

Cohort 4

Student I.D. 04080689

Clinical Essay 2

Word Count: 4917

Abstract

This paper chooses to discuss political and ethical issues that have surrounded the practice of psychotherapists and clinical psychologists predominantly in the UK and the US over the last fifty years in working with sexuality. In doing so a reflective stance is taken in order to inform the reader of the author's stage of training and concern for the ethical issues raised. The paper covers work concerning the practice of psychotherapy for Lesbian, Gay and Bisexual clients as well as some of the historical, social and political contexts for this work. The author maintains a position throughout that a reflective stance is essential not only for accreditation purposes or individual development as a therapist, but also because, as in the example of psychotherapy with LGB clients, therapist values and beliefs cannot be avoided and therefore therapists as professionals and as citizens must be accountable for them.

Introduction

As a trainee clinical psychologist I am becoming increasingly aware of the need to develop my ethical and political awareness in specific regard to working with clients. Equally I am aware that my on-going exposure to cases has implications for my world-view and actually forces me to think in more depth about my beliefs generally. I have chosen to focus on the notions of politically and ethically motivated psychotherapy precisely because these issues are so pertinent to my development as a clinical psychologist as well as having deep resonance for my position as a person and citizen of the United Kingdom.

These issues are not simply a matter of choice in the life of a nascent clinical psychologist; such as choosing this or that essay question to answer. In fact, as the BPS stipulates, they are matters of professional duty. The BPS thus states that training courses should foster in their trainees the development of certain ethical positions and approaches to working with clients. For example, in terms of fostering a general ethical position, UK doctoral courses in clinical psychology must ensure that:

> **"B.1.1. …Trainees work will be based on the fundamental principle that people have the same human value and the right to be treated as unique individuals."**

And…

> **"B. 1.2.2 A professional and ethical value base, including that set out in the BPS Code of Conduct, the DCP statement of the Core Purpose and Philosophy of the Profession and the DCP Professional Practice Guidelines"**

(BPS revised accreditation criteria 2003; Required Learning Outcomes and the structure of training, Appendix 3, pp2-3)

In addition to the development of a professional ethical stance, the BPS also highlights the need for tomorrow's clinical psychologists to be developing their reflective and critical thinking capacities. That is:

> **"B.1.1.6 High level skill in managing personal learning agenda and self care, and in critical reflection and self awareness that enable transfer of knowledge and skills to new settings and problems."**

And….

> **B.1.3.1**
>
> **" 'Transferable Skills' to include: demonstrating self awareness and working as a reflective practitioner. Ability to think critically, reflectively and evaluatively."**

(BPS revised accreditation criteria 2003; Required Learning Outcomes and the structure of training, Appendix 3, p3)

These current concerns of ethical and reflective practice for clinical psychologists and their accredited courses are perhaps shown most clearly by examining concrete issues rather than relatively abstract documents. Therefore, the present essay will focus on clinical, ethical and political factors of clinical psychology in relation to issues around sexuality. More specifically, this will revolve around longstanding debates and concerns around the role of the clinical psychologist in working with psychological distress in individuals where sexuality may or may not be of relevant concern. This is an area that I anticipate my own future clinical case-load is likely to touch. In keeping with the above stated BPS standards, this essay will try keep in focus my own clinical, ethical and reflective development as a trainee in relation to the literature covered.

In approaching these issues in a reflective and critical way, I first need to remind myself of where I am coming from ethically and politically. For example, there are certain 'facts' about my existence. I am a 31year old male, hetero-sexual, Caucasian. I consider myself British and Scottish, having English, Scottish and Irish ancestry. I am a fairly secular person who has imbibed a sceptical view of organized religion from my parents and which sat well with the apolitical and atheistic environment of the East Coast of Scotland in the 1980's and 90's. I am of middle class socio-economic status, with social work, nursing and further education as parental career choices. I undertook a psychology degree as my educational horizons always seemed to include attending a university. I studied sociology, philosophy and psychology. I have lived in England for nine years. I have chosen and been accepted on a Clinical Psychology Course which encourages open reflection and views social and psychological knowledge as at least partially constructed phenomena. These are some phenomenological 'realities' of my 'being in the world' (Heidegger, 1953). These experiences shape my worldview and influence my choice of career as a clinical psychologist.

Working through these historical contexts are the strands of my development as a trainee clinical psychologist. Skovholt & Ronnestad (1992) discuss an 'eight stage' model of psychotherapist development. From my experiences of working with clients attempting personal change, I am sceptical of stage theories that are often rigid and unidirectional. I feel that processes of personal change are often, cyclical, iterative, fluid and multi-dimensional. However it is nevertheless useful for me to locate my experiences as a trainee within a potentially normalising developmental framework, i.e. *'It's normal to experience that at this stage of training (isn't it?!)'*.

Skovholt & Ronnestad's (1992) description of the fourth stage: 'conditional autonomy' may well approximate to my perceived level of professional development. Here the central task of the trainee "entails a concentrated period of socialization/enculturation into the field……[where]….the predominant affect is variable confidence." (Skovholt & Ronnestad, 1992, Ch5, p42-43). The authors explain that each of the stages unfolds within an ethical and competency framework, although no explicit mention is given to the kinds of ethical dilemmas or considerations one might face at a particular point in training. Or indeed how one might approach dilemmas generally at particular developmental stages. These considerations are important in terms of my development as a reflective practitioner as well as in relation to the kinds of ethical difficulties faced by clinical psychologists.

In my own training, to date, I have stumbled across a couple of ethical issues rather than having been prepared for or waiting in anticipation for them. For instance, in my first placement of older adults I worked within a service that did not give 'pre-diagnostic' counselling to persons who were undergoing neuropsychological tests to determine the presence or absence of dementia. Although not ethically unsound per se, I felt this approach not to be best practice in terms of preparing clients for the process on which they were embarking and the kinds of knowledge that may emerge from assessments. This was something I discussed with my supervisor although the basic format of the service remained in place. This left me in difficult situations, I felt, when having to disclose to individuals for the first time that it was very likely that they may be dementing. This area also touches ethical issues concerning, for example, disclosure of dementia to someone without the capacity to retain or understand the information, or non disclosure due to family concerns that the information will cause severe and deleterious consequences for the person's mental health.

This kind of experience leads me to imagine the kind of ethical dilemmas that will inevitably emerge for me during the rest of my training and later career. In terms of stages of development, does this mean that I am at an 'ethical neonate' stage? If so, is this normal for trainees? One area I have had very little experience in so far is that of sexuality in psychotherapy. In my present placement, I am aware that my beliefs about religion and homosexuality differ markedly to those of some of my senior colleagues. In articulating this difference with them, I have begun to question what my views would be around working with, for example, someone who was unhappy with their sexual orientation or was experiencing bullying and homophobia. Indeed, it may be that one of my upcoming cases will touch on some of these issues. The following section then will explore some of the literature on sexuality and psychotherapy. In examining this material, I hope to reach a fuller understanding of my own position.

Social & Legislative Context

Before entering into literature specific to psychotherapeutic aspects of sexuality it is worth bearing in mind the historical, social and political context in which mental health services operate. This particularly so as one of the aims of clinical psychology is to use psychological data to think about issues not simply at clinical levels, but also at organizational and societal levels. (BPS, 2001).

Broadly speaking the emergence of new social movements from the 1960's onwards including: *The Gay Liberation Movement, Gay Rights Movement, Front Homosexuel d'Action Révolutionnaire* and *Allgemeine Homosexuelle Arbeitsgemeinschaft* across the US and Europe began steadily to raise the political profile of gay issues onto the mainstream political and cultural agenda (Beuchler, 1999). Despite this, in the UK, it is only in the last 10 years that some truly significant changes to government legislation have come into force. For example:

2000 Homosexual individuals allowed to serve in the armed forces

2000 Parity with heterosexual individuals in terms of age of consent to sex for males

2002 The introduction of provisions to allow same sex partners to adopt children

2003 The repeal of section 28

2003 Employment regulations to prohibit workplace sexual orientation discrimination

2004 Introduction of civil ceremonies for same sex partners

(Scott et al, 2004).

That such changes to the legislative framework are occurring is a commendable facet of the New Labour project in the UK. It is also perhaps surprisingly late, given the decades of work carried out by the above mentioned social movements, reflecting a much slower pace of change than one might have hoped for. Perhaps change in the wider social sphere, like that of individuals themselves, is at times slow, iterative and with attendant setbacks and ambivalence.

Diagnostic and Statistical Manual (DSM)

In 1952 the publication of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorder first edition (DSM 1) classified homosexuality as a sociopathic personality disturbance. By 1973, the DSM's second edition (DSM-II) was modified by the Board of Trustees of the American Psychiatric Association (APA), who voted to eliminate the general category of homosexuality, and replace it with 'sexual orientation disturbance' (Davison 2005). In 1980 DSM III created the category 'ego-dystonic homosexuality' (although there was no category: ego-dystonic *heterosexuality*). It was not until the revised DSM III emerged that this category was dropped; following lobbying from outside and inside the American Psychiatric Association (Bayer 1980). Until this point in 1987 homosexuality had been officially considered a mental illness.

This is an often cited example of the socially constructed nature of diagnostic manuals, such as the DSM, and the use of therapies built upon such classification structures. Here the question is not, does this example fatally undermine such classification systems (DSM V will be here soon), but rather, in what other ways do political and moral issues work their way into and through the domain of psychotherapy?

Mental Health Provision & Education

One way of finding political factors and moral choices that contextualise psychotherapy is to examine some of the state institutions that purport to develop and nurture individuals in our society. If negative beliefs and values can be found here regarding sexuality one might well question the degree to which our society has moved towards a truly accepting position of diversity in sexual orientation. In the general population Seltser (1992) found that individuals were more likely to hold anti-homosexual attitudes if they were politically conservative, religious, older, less educated, male, married or widowed. The National Service Framework for Mental Health (NSF) provision in England and Wales includes no specific reference to Lesbian Gay and Bisexual individuals (DoH: http://www.dh.gov.uk.). In light of this PACE (Promoting

Lesbian and Gay Health and Wellbeing 2006 enlist the standards of the NSF and incorporate LGB issues into the text in a call for more consideration by the government and wider society of the margininalisation of LGB and Mental Health Issues. See below.

NSF Standard one: *"Promote mental health for all*

- Include reference to and information about lesbians, gay men and bisexuals, including relevant organisations, in all publicity - promote positive images.
- Liaise with relevant lesbian and gay user and community groups, including those providing services.
- Recognise effects of homophobia and develop materials which challenge it - use the social model of disability.
- Challenge notions and negative images of mental "illness" that are prevalent in lesbian, gay and bisexual communities as elsewhere.
- Include information about and positive images of lesbians, gay men and bisexuals in schools and other educational establishments.
- Promote self-help, counselling, advocacy and other support available from lesbian, gay and bisexual organisations.
- Develop resources specifically targeted at lesbians, gay men and bisexuals, especially those "coming out"."

PACE Website. Promoting Lesbian and Gay Health and Wellbeing 2006.

Despite this call to arms, Wells (1997) found that mental health nurses across the UK were no different than the general population in that around 77% of them were found to be either moderately or severely homophobic. High levels of homophobia in the nursing profession have been found elsewhere (Dotson, 2000; Platzer, 1998). It may be that nurses are merely reflecting the views of the society at large as well as those views reproduced in institutional and educational settings for nurses. Whatever the cause, the reality for LGB individuals is that they are frequently discriminated against either through homophobia or hetero-sexism when in contact with UK health provision and health professionals. (Scott et al, 2004).

This is also true in the mainstream Educational settings where few schools or colleges, although they have bullying schemes in place, have anything specific for homophobic bullying. Nor is it clear that school nurses have been given adequate training in spotting and working with emotional disturbance linked to homophobic bullying. Despite the recent repeal of section 28 it is also clear that schools have been largely unable to incorporate same sex issues in their sex education packages for fear of parental or media backlash (Scott et. al. 2004)

Mental Health Symptomatology

Echoing the fact that health and educational establishments are still found to be either hostile or blind to the needs of individuals with non heterosexual orientations, there is a growing body of evidence that suggests that Gay men, lesbians and bisexuals report greater levels of mental health difficulties. (King et al 2003).

LGB individuals also experience greater levels of bullying at school, hate crime, rejection and discrimination, invalidation, marginalisation, denial, making invisible, silencing, negative stereotyping, pathologisation (seeing homosexuality as an illness or abnormality; believing that the problems that gay people experience are a result of their sexuality rather than other people's treatment of them. They also experience teasing, joking, ridiculing, patronising, treatment as second class citizens. They can be viewed as as sinful, immoral, predatory, and even dangerous to children (www.pacehealth.org.uk 2006)

Experiencing this homophobia increases risks for developing depression, anxiety and low self esteem. Correspondingly, suicide and self harm rates are also elevated in gay men, with Ramafedi (1999) estimating prevalence of suicide and self harm in the range of 20-42% across a range of studies. Hutchison et. al. (2003) found young gay men living in an urban environment to be around seven times more likely to attempt suicide than the general population.

If mental health difficulties are a significant negative consequence for individuals with diverse sexual orientations in our society, often as the result of continued direct or indirect prejudice and abuse, how has the approach of psychotherapists and clinical psychologists attempted to address these issues?

Sexuality & Psychotherapy

In terms of psychotherapy, a plethora of main-stream psychiatric and psychological techniques from psychoanalysis to behaviour modification continued to be applied over the last fifty years in order to 'cure' people of their homosexuality (Murphy, 1992). Such strategies included, teaching individuals 'social skills' to improve their heterosexual dating prowess and 'exposure training', where male homosexual individuals were simply encouraged to have sex with women. Other techniques included aversion therapies which utilized unpleasant images, chemicals and even electric shocks being paired with visualization or imagery of the act of homosexual sex in order to condition aversion and reduce homosexual behaviours (Smith et al 2004; King et al 2004; Murphy, 1992).

At present unfortunately not all clinical psychologists are in agreement of how to approach working with issues mental health issues in the context of clients with diverse, non heterosexual orientations. In fact, presently not all clinical psychologists work or would want to work affirmatively with LGB clients anyway. Jordan & Deluty's US study (1995) showed that around 13% of psychologists still viewed homosexuality as a disorder. Around 6% of therapists supporting behavioural techniques to change sexual orientation. Additionally, therapists may be unaware of how their own values and views shape their responses negatively towards LGB clients (Eubanks-Carter et al 2004). One US study found that psychologists rated clinical vignettes of depressed clients as needing more medication when they were informed that the client was of a LGB orientation rather than a heterosexual one (Biaggio et al 2000).

Despite some evidence that LGB clients use therapy more often than heterosexual individuals (Cochran, Sullivan & Mays, 2003; King & McKeown, 2003), Eubanks-Carter et al. (2005) describe several main factors which may negatively affect therapists in their work with Lesbian, Gay and Bisexual clients (LGB). There is the issue of ignorance. For example, I have received a day's training in sexuality issues on my course in the first year, and feel I would benefit from more discussions around these topics. Elsewhere, it is also often the case that therapists have not received adequate training in working affirmatively with LGB clients. Phillips & Fischer (1998) found that 108 final year clinical and counseling psychology graduates in the US felt ill prepared to work with LGB clients.

Literature suggests that the evidence base for 'reparative' or 'conversion' therapies (therapies that purport to change the sexual orientation of an individual, usually from homosexual to heterosexual) indicates it to be at best ineffective and at worst deeply damaging, where it can reinforce an individual's sense of failure morally and religiously and increase self criticism and self hatred. Smith et. al (2004) showed that most participants who engaged in 'reparative therapies' were 'responding to complex personal and social pressures that discouraged any expression of their sexuality'. In addition, some commentators have stated that 'choosing' reparative therapy is in fact an oxymoron. Gerald Davison, a proponent of behavioural approaches to curing homosexuality 30years ago, now states that by offering these therapies, therapists are de facto colluding with an 'internalised homophobia' (Davison 2005).

The concept of internalized homophobia has been a key concept for me in researching this essay. This is because it is here that psychological phenomena intersect with wider societal forces and forces me to reflect on the limitations of psychological approaches to certain social issues. Here is a way of understanding a mechanism by which an individuals' mental health domain is dominated by symptoms which in themselves may be the signature of powerfully hostile and negative values and practices within the wider society. This is a view of individual realities being deeply inter-subjective in nature and clearly open to relations of power and ideology. Gramsci's notion of hegemony (although used originally in relation to ideas of class relations) is a useful concept to bear in mind here.

Power, Ideology and Scientific Legitimation

Hegemony, or leadership, is in this case the dominant ideas, or the ideas of the dominant sections of society becoming accepted, internalised and normalised by the wider society (Gramsci, 1971). Concepts such as the inherent 'wrongness' of homosexuality or homosexual sex acts, and moral arguments focusing on the naturalness, and necessity of procreation as the defining and archetypal human relationship end goal. Concepts and discourses around 'poofs, queers, gays' that stigmatise, disempower and that go unchallenged every day in the speech acts of individuals inside and outside of institutions. This might be achieved, perhaps not necessarily deliberately, through state institutions, such as law enforcement, legislation (as seen above), education, health-care, the economic sphere and also crucially via the media. The experience for individuals who have not conformed to the dominant or hegemonic ‘common sense’ would be one of potentially crushing alienation. This is precisely why the above mentioned social movements of the 1960’s onwards were so important. That is in order to reclaim a space within society that was separate from the dominant ideology. Individual experiences of alienation and suffering could be at least partially transcended by political action and solidarity.

The continued struggle in the US despite APA disapproval regarding the ongoing practice of ‘reparative therapy’ (Nicolosi & Nicolosi 2002) again shows that religious and moral doctrines clearly intersect with medico-psychological & scientific knowledge. This was a point made by Thomas Sasz some forty years ago (Sasz, 1961). One factor in support of this supposition is the legitimizing power wielded in our society by positivistic scientific knowledge and rhetoric. Here moral opinions concerning the inherent nature and value of sexual orientation are formed through historically accumulated moral doctrines. They can subsequently be legitimized through appeal to empirical verification (See Appendix 1). Thus the religious right so often at loggerheads with basic scientific theories with substantial empirical backing, (such as the Darwin’s theory of evolution) can suddenly embrace studies which support or provide uncritical and de-contextualised examinations of sexuality and sexual orientation.) That this is so in the US is clear where the terms of the debate are explicitly stated and boldly asserted. This clarity although perhaps unnerving to a more secular UK society, does serve to highlight some of the more latent yet no less powerful values and attitudes reproduced across UK institutions such as those of health and education as mentioned above as well as in the broader society.

Value Neutrality

Is there such a thing as value neutral psychotherapy? It may be better to ask the opposite question. That is, can there in fact be such a thing as psychotherapy that is not ethically or politically motivated? Certainly, the route to practicing as a clinical psychologist in the UK involves an adherence to an ethical code which in theory if transgressed would result in the de-accreditation of the individual psychologist. In other words, one must take a particular ethical stance before in order to begin as a clinical psychologist. I say 'in theory' because if the institutions within which the Clinical Psychologist works can be blind to homophobia and heterosexism how will transgressions (perhaps even well meaning ones) by individual psychologists be seen, reported and acted upon?

The above literature in the concrete issues of sexuality, psychotherapy and their social, historical and political contexts has made clearer to me that there is no such thing as a value neutral psychotherapy. Although there is a kind of open and curious neutrality within sessions where a therapist can attempt to put his beliefs to one side momentarily and actively choose not to visit upon the client his own thoughts and conjectures in the way that a friend or an acquaintance might do. That this is part of being a therapist, the limiting of one's disclosures and the careful consideration of ones own thoughts and remarks, shows how a psychologists beliefs and values can be used positively. This is precisely why in my view the BPS and DCP are entirely correct to demand reflective and critical thinking from trainees, training courses and qualified clinical psychologists.

The issue of whether or not homosexuality is a mental disorder has long been decided and yet very deeply held moral positions (just as my own is) regarding the inherent 'rightness' or indeed 'wrongness' of homosexuality are still at the crux of this matter. So much so, that in America at least, psychological knowledge is still being used to legitimise practices that have been empirically found to be harmful to the mental well being of individual clients.

The history of clinical psychology therefore, a profession that I am trying hard to join, has not in my view always been spotless. In terms of my own values I should be clear in articulating them. That is, it is my view that there never has been, is not now and never will be anything inherently or morally wrong with being attracted to or having sexual intercourse with someone of the same sex as oneself. For me, to suggest that this is not so simply does not make sense. This is my moral position, and I take that along with many other of my moral positions into my practice as a clinical psychologist.

For me these issues around politically or ethically motivated psychotherapy demand a consideration of the clinical psychologist’s role beyond that of the traditional idea of the scientist practitioner. In this respect our view of what ‘science’ is comes into the question, particularly in relation to endeavours that have active subjects to study rather than non-sentient objects.

Conclusion

What kind of therapist do I want to be? What kind of clinical psychologist? What kind of person? Am I open enough and curious enough to discuss issues of sexuality with clients? Will I refuse to work with a client who wishes to change his or her sexual orientation or gender? Do I, or will I obtain the necessary expertise to discuss with confidence issues around sexual identity confusion? Should I disclose my own sexual orientation in therapy and would I want to? Will my body language betray my own lack of confidence in working with a client who has a sexual orientation different to that of my own? Will I miss that certain presenting symptoms are part of a wider process of sexism or homophobia that is wearing away at a client? Will I focus too exclusively on somebody’s sexuality, even when it is not what they are asking me to do? Will I collude with teams who discuss clients in particular ways or with institutional practice that is blind to differing sexual orientations? These are the questions that I have held in my mind throughout this essay.

In answer to the above questions, I can only aim for some of the following answers. As a therapist, a clinical psychologist and a person, I would hope to be and continue to be open and curious enough to discuss issues as lead by or in collaboration with the client. I would not refuse to work with a client who wished to change his or her sexual orientation although I would not offer to facilitate that change. I would hope to be able to discuss with someone their reasons for changing, bearing in mind issues of internalised homophobia. I see reading for and writing this essay as a beginning in developing my own expertise and knowledge in the field of sexuality issues, and hope that by doing so I will gain confidence in thinking about and discussing them. I am clear that in disclosing for example my own sexual orientation, as with any self disclosure, I may be limiting someone in terms of who they feel they can be within a session. Any self disclosure I make, including that of my own sexual orientation, would have to be weighed up, at the time and in the interests of the given client. As a matter of principle though I do not rule out of hand using therapist self disclosure. The remaining questions I can only trust in my own development towards integrity, a final stage in Skovholte & Ronnestad's (1992) model of the therapist's evolving professional self.

Finally, as an individual citizen I have to remain aware that I am responsible for my own actions. This includes joining a profession. In the case of Clinical Psychology, I have chosen to join a profession which I believe endeavours to work positively towards the amelioration of individual distress; be that caused by genes, individual histories or wider social factors. Should this profession ever deviate from that path, as helping professions have done in the past, as a citizen I would again have to weigh my own choices and responsibilities.

Critical Evaluation

This essay has not focused enough on the affirmative role that clinical psychologist can play in support of social justice issues, as well as in regard to specific mental health distress. Goodman et. al. (2004) discuss how psychologists can facilitate positive change through ongoing self-examination as alluded to in this essay. Crucially however they go on to elucidate how by sharing power, psychologists can begin to help clients by giving voice to their experiences and beginning to locate individual experiences within a social and historical framework where relevant. In doing so, psychologists can, if they remain informed and reflective themselves, begin to facilitate ‘consciousness raising’ and help to build on strengths that clients possess. This may be done in the consulting room at an individual level, but as the BPS suggests, Clinical Psychologists should also not be afraid to think at organizational and societal levels in order to aid problem solving and decision making in the interests of the welfare of all.

REFERENCES

American Psychiatric Association (1980). Diagnostic *and Statistical Manual of Mental Disorders, Third Edition, Washington, D.C.*

American Psychiatric Association (1987). *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised, Washington, D.C.*

Bayer, R. (1981). *Homosexuality and American Psychiatry, The Politics of Diagnosis.* Princeton: Princeton University Press.

Biaggio, M., Roades, L.A., Staffelbach, D., Cardinali, J., & Duffy, R. (2000). Clinical Evaluations: Impact of sexual orientation, gender and gender role. *Journal of Applied Social Psychology, 30, 1657-1669.*

British Psychological Society (2001) *Professional Practice Guidelines.*

British Psychological Society (2003) *Revised Accreditation Criteria*.

Cochran, S.D., Sullivan, J.G., & Mays, V.M., (2003) Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology, 71, 53-61.*

Dotson, L.G. (2000) Adolescent Homosexuality and Culturally Competent Nursing. *Nursing Forum, Jul-Sep. 35 (3)277-298.*

Eubanks-Carter, C., Burckell, L.A., Goldfried, M.R., (2005). Enhancing Therapeutic Effectiveness With Lesbian, Gay and Bisexual Clients. *Clinical Psychology: Science & Practice, 12, 1, 1-18*

Davison, G.C. (2005) Issues & Non-Issues in the Gay-Affirmative Treatment of Patients Who are Gay, Lesbian or Bisexual. *Clinical Psychology: Science & Practice, 12, 1, 25-28*

Division of Clinical Psychology (2001) *The Core Purpose and Philosophy of the Profession.* British Psychological Society.

Goodman, L.A., Liang, B., Helms, J.E., Latta, R.E., Sparks, E., Weintraub, S.R. (2004) Training Counseling Psychologists as Social Justice Agents: Feminist and Multicultural Principles in Action, *The Counseling Psychologist, 36, 2.*

Gramsci, A. (1971), *Selections from the Prison Notebooks*, Lawrence and Wishart, London.

Heidegger, M (1953) *Being and Time*. Translated by Joan Stambaugh. Albany: State University of New York Press.

Jordan, K.M. & Deluty, R.H. (1995). Clinical Interventions by psychologists with lesbians and gay men. *Journal of Clinical Psychology, 51, 448-456.*

King, M., & McKeown, E. (2003) *Mental health and social wellbeing of gay men, lesbians and bisexuals in England & Wales. A summary of findings*. Mind.

Nicolosi, J., & Nicolosi, L.A. (2002) *A parent's guide to preventing homosexuality*. Downers Grove, IL: Inter Varsity Press.

PACE: Promoting Lesbian and Gay Health and Wellbeing Retrieved 1st July 2006. www.pacehealth.org.uk

Phillips, J.C. & Fischer, A.R. (1998) Graduate Students' training experiences with lesbian, gay and bisexual issues. *The Counseling Psychologist, 26, 712-734.*

Platzer (1998) Learning to Accept. *Nursing Times, 94, 16, 22-24*

Remafedi, G. (1999) Suicide and sexual orientation: nearing the end of controversy? *Archives of General Psychiatry, American Medical Association 56, 876-885.*

Safran, S. (2005) Affirmative, Evidence-Based and Ethically Sound Psychotherapy With Lesbian, Gay, and Bisexual Clients. *Clinical Psychology: Science & Practice, 12, 1, 29-32*

Sasz, T. (1961). *The Myth of Mental Illness*. New York: Hoeber-Harper.

Scott, S.D., Pringle, A., Lumsdaine, C. (2004) *Sexual Exclusion- Homophobia and health inequalities: a review: A review of health inequalities and social exclusion experienced by lesbian, gay and bisexual people.* UK Gay Men's Health Network.

Seltzer, R. (1992) The social location of those holding anti-homosexual attitudes. *Sex Roles; A Journal of Research, Vol 26, 9-10.*

Skovholt, T.M., & Ronnestad, M.H. (1992) *The Evolving Professional Self; Stages and Themes in Therapist and Counselor Development*. Wiley Press.

Smith G., Bartlett A., King M. (2004) Treatments of homosexuality in Britain since the 1950s - an oral history: the experience of patients. *British Medical Journal; 328:427-9.*

King, M., Smith G., Bartlett A. (2004) Treatments of homosexuality in Britain since the 1950s - an oral history: the experience of professionals. *British Medical Journal, 328, 429-32.*

APPENDIX 1 ‘Reparative Therapy’ website.

http://www.newdirection.ca/research/index.html

Homosexuality and the Possibility of Change

An Ongoing Research Project

- **Main Introduction**, Disclaimers, Explanation of Format, Standard Categories and Definitions, etc.
- **Summary of Evidence Found**
- Common Objections Raised about Research Studies
- List of Excluded Articles
- Bibliography

31 Research Summaries

- David H. Barlow and W. Stewart Agras: Fading to Increase Heterosexual Responsiveness in Homosexuals
- Joseph Berger: The Psychotherapeutic Treatment of Male Homosexuality
- Irving Bieber et al.: Homosexuality: A Psychoanalytic Study
- Lee Birk: The Myth of Classical Homosexuality
- Edward J. Callahan: Covert Sensitization for Homosexuality
- Alejandro Cantón-Dutari: Combined Intervention for Controlling Unwanted Homosexual Behavior
- Albert Ellis: A Homosexual Treated with Rational Psychotherapy
- William Freeman & Robert Meyer: A Behavioral Alteration of Sexual Preferences
- Daniel H. Golwyn & Carol P. Sevlie: Adventitious Change in Homosexual Behavior During Treatment of Social Phobia With Phenelzine
- Samuel B. Hadden: Treatment of Male Homosexuals in Groups
- J.A. Hadfield: The Cure of Homosexuality
- Lawrence J. Hatterer: Changing Homosexuality in the Male
- Harvey E. Kaye et al.: Homosexuality in Women
- Jay L. Liss & Amos Welner: Change in Homosexual Orientation
- Houston MacIntosh: Attitudes and Experiences of Psychoanalysts
- William Masters & Virginia Johnson: Homosexuality in Perspective
- Peter Mayerson & Harold Lief: Psychotherapy of Homosexuals
- Richard E. McCrady: A Forward-Fading Technique for Increasing Heterosexual Responsiveness in Male Homosexuals
- Elizabeth Mintz: Overt Male Homosexuals in Combined Group and Individual Treatment
- N.A.R.T.H.: Survey of Sexual-Orientation Change Part I: Survey of Individuals

- N.A.R.T.H.: Survey of Sexual-Orientation Change Part II: Survey of Psychotherapists
- E. Mansell Pattison & Myrna Loy Pattison: "Ex-Gays": Religiously Mediated Change in Homosexuals
- John S. Poe: The Successful Treatment of a 40-year Old Passive Homosexual
- Kim W. Schaeffer et al: Religiously-Motivated Sexual Orientation Change
- Kim W. Schaeffer et al: Religiously-Motivated Sexual Orientation Change: A Follow-Up Study
- Roberta Ann Shechter: Treatment Parameters and Structural Change: Reflections on the Psychotherapy of a Male Homosexual
- Ariel Shidlo and Michael Schroeder: Changing Sexual Orientation: A Consumers' Report
  - Comparison of the Research of Spitzer with the Research of Shidlo and Schroeder
- Charles W. Socarides: Homosexuality
- Robert L. Spitzer: Can Some Gay Men and Lesbians Change Their Sexual Orientation? 200 Participants Reporting a Change from Homosexual to Heterosexual Orientation
  - Summary of "Peer Commentaries on Spitzer (2003)"
- Gerard J.M. van den Aardweg: On the Origins and Treatment of Homosexuality
- Leon Wallace: Psychotherapy of a Male Homosexual
- Joseph Wolpe: "Spontaneous" Reversal of Homosexuality

New Direction offers Christian support to men and women choosing to leave homosexuality, and equips the church to minister effectively and compassionately.

We offer Christian support to men and women choosing to leave homosexuality by:

1. **Providing an opportunity for individuals to consider other alternatives to those which are generally offered, to speak to someone who's been there, and to ask questions in a non-threatening, unpressured atmosphere.**
2. **Providing support groups where men and women who want to leave homosexuality can:**
   - speak freely in a safe and confidential place;
   - be encouraged by hearing how others are dealing with their struggles;
   - hear about the love of God for them and about their true identity in Him; and
   - learn about homosexuality and the process of healing and change.
3. **Providing personal counselling and/or counselling referrals.**

Planning, Running and Evaluating a Six Week CBT Group for People Who Hear Voices

Nathan O'Neill

Cohort 4

Student I.D. 04080689

Word Count: 4997

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ABSTRACT

As part of the ongoing commitments of the CMHT in ---- area, a brief six week cognitive behavioural group is periodically offered to service users. Here existing group formats were adapted and modified in line with recent cognitive behavioural evidence and work by the 'Hearing Voices Network'. Evidence showed some positive changes in participants' beliefs about their own voices and perceived control over voices. Group members reported a generally positive experience within the group particularly the sharing of knowledge and experiences although the subject matter of the group may have been at times difficult and anxiety provoking. These limited findings may suggest both the need for a group lasting longer than six weeks to facilitate the implementation of further cognitive techniques as well as a more process oriented evaluation methodology to better elaborate the value and limitations of such groups for this service in the future.

BACKGROUND LITERATURE: Schizophrenia, Psychosis & Hearing Voices.

In a large study of 15,000 people, 2.3 percent reported having heard voices frequently. This contrasts with a schizophrenia prevalence of around one percent in the general population (Tien, 1991). Within the voice hearing population a significant number of people have never been psychiatric patients (Honig et al., 1998) and many people who hear voices report finding them helpful or benevolent (Romme & Escher, 1993).

However, hearing voices or auditory hallucinations remains a first-rank symptom of schizophrenia (Schneider, 1959) and is often seen as a prime symptom of psychosis (American Psychiatric Association, DSM IV, 1994). Many of those who experience hearing voices report the experience to be highly distressing with correspondingly high impact on their everyday lives. Experience of psychotic symptoms has also been found to reduces life expectancy and is a high risk factor for suicide (Harkavy-Friedman et al., 2003). Honig et.al (1998) found that within the psychiatric population there are generally considered to be three main diagnostically categorized groups of patients that hear voices; schizophrenia (around 50 percent); affective psychosis (around 25 percent) and dissociative disorders (around 80 percent).

Honig et. al (1998) also studied the differences between non-patient and patients who reported hearing voices. In this study both patients and non-patients reported hearing voices both inside and outside their heads. For non-patients the content was positive or the hearer had a positive view of the voice and felt in control of it. By contrast, the patient group was more frightened of the voices and the voices were more critical (malevolent) and they felt less control over them (Honig et al, 1998). The experience of hearing critical voices is often very anxiety provoking has been found to lead to high levels of depression and suicidality (Harkavy-Friedman et al., 2003).

Anti-psychotic medication reduces symptoms in the majority of those experiencing psychosis and remains a first line of defense in the treatment of psychoses (Fleischhaker, 2002). However, it has been estimated that around 30% of patients still experience hearing voices despite high doses of anti-psychotic medication (Curson, Barnes, Bamber, & Weral, 1985; Newton et.al 2005). Indeed, conventional approaches in psychiatry to the problem of voice hearing have often been to ignore the meaning of the experience for the voice hearer and concentrate on removing the auditory hallucinations by using medication (Bentall, 2004; Romme & Escher, 1989). Other psychiatrists have sought to move away from a purely medical view of such experiences. Psychiatrist Marius Romme has hypothesized that anti-psychotic medication may impede healing by preventing emotional processing associated with the contextual meaning of hearing voices (Romme & Escher, 2000).

Alongside these developments a number of Psychologists have shown that Cognitive–Behavioural Therapy (CBT) combined with standard psychiatric care can lead to significant clinical benefits over standard care alone (Pilling et al, 2002; Drury, Birchwood, & Cochrane, 2000; Haddock, Morrison, Hopkins, Lewis, & Tarrier, 1998; Kuipers et al., 1998; Morrison, 2002). Indeed Some practitioners advocate that CBT is the most appropriate, evidence based approach (Tarrier, Haddock, Barrowclough, & Wykes, 2002).

Recent advances in CBT have also given rise to developments in group approaches. Evidence suggests that groups with: clear structure, boundaries, a ‘here and now’ focus on specific issues and which attempt to reduce anxiety at an early stage, can be successful in reducing the impact of psychotic symptoms (Chadwick et. al 2000; Wykes et.al 2005; White, 2000). Additionally, the peer support, sharing of knowledge / experiences and normalizing effect of being part of a group may well be highly implicated as stimuli to therapeutic change in and of themselves (Shermer, 1999; O’Neil, 1991; Yalom, 1983).

Hearing Voices Network

Hearing Voices Groups in the UK began in 1988 in Manchester. They have typically brought together those who experience voice hearing for mutual support, education and development. The groups sometimes include relatives and carers of people who hear voices and are usually facilitated by individuals who have or have had experience of voices. The aims of the groups have been to provide friendly and secure environments away from mainstream services allowing people to feel accepted and begin to explore their experiences with voice hearing. A strong emphasis is placed on open ended groups where member’s progress may be reviewed each 20 weeks or so, moving from structured help to more narrative approaches to exploring voice hearing. Groups aim to help individuals integrate the experiences into their lives in order to regain a degree of autonomy, power and control from their symptoms (Hearing Voices Network, 2005).

DESIGN OF THE GROUP

Much of the recruitment and day to day running of the group was carried out in partnership with Nurse P, a psychiatric nurse working in the local day centre. My remit was to provide psychological knowledge, development skills, facilitation skills and to evaluate the group under supervision from the B Grade Consultant Clinical Psychologist who had made this project available.

Ethical Considerations

Hertfordshire University and Hertfordshire Partnership NHS Trust Research and Development deemed this project not to need ethical approval from an ethics committee on the proviso that this project would not be put forward for publication. All participants and staff gave their consent to take part in the group and its evaluation (Appendix 1).

Methodology

The following criteria were developed in negotiation with the CMHT, Nurse P, Day Centre Staff and Project Supervisor in order to put together a group which would be congruent with the stated needs of all stake-holders. A twenty minute meeting with either the trainee or nurse was arranged with each of the prospective group members to assess inclusion / exclusion criteria and to provide people with an initial point of contact and information about the group and to gain consent (See Assessment Protocol, Information

Sheet & Consent Form, Appendices 1, 2 & 3). Group members were then told by post of their inclusion in the group.

Inclusion criteria

1. Are primarily distressed from hearing voices
2. Want to work as a member of a Hearing Voices Group
3. Usually have a diagnosis of psychosis/severe mental illness such as schizophrenia or affective psychosis
4. Must have a contact who will liaise with the group facilitators, such as a care co-ordinator or key worker
5. Must be presently known to adult mental health services, i.e. on computer monitoring system.
6. Where possible they will already be attending the day centre.

Exclusion criteria

1. Present intoxication with substances such as alcohol, or drugs
2. Present extreme paranoid ideation which may be exacerbated by group work

Evaluation measures

The following evaluation measures were chosen in order to obtain data about changes which may occur for participants In relation to cognitive appraisals or beliefs held about voices we used the Revised Beliefs About Voices Questionnaire (Chadwick et. al., 2000a). Additionally, the trainee developed a Visual Analogue Scale (VAS) to measure some of the aspects specific to the group such as voice symptoms and anxiety in the group setting. It was decided to use the VAS which has good psychometric properties and has been used in psychotic populations (Morrison 1997). Finally a short post-group, 8 open-ended item evaluation measure, developed by the trainee, was administered at the end of the final session for group members to give feedback on their experiences of the group if they wished.

1. The Revised Beliefs About Voices Questionnaire (BAVQII-Chadwick, 1998). 35 4-point closed item questionnaire, 5 subscales (pre & post group).

2. Visual Analogue Scale (pre, mid and post group).

3. End of group short evaluation form 8 open questions.

(See Appendices 7, 5, & 6)

Group demographics

Three of the potential group members came from the CMHT. Nurse P who worked in the day centre obtained eight potential group members making an initial overall N=11. In pre-group discussion with either Nurse P, or the project supervisor three clients felt that the group may in fact be too much for them and could aggravate symptoms. They therefore decided not to participate. Another client felt that she would like to participate but that the majority of participants would be much older than her. She reported that she would prefer to attend a group for people around the age of 20years and declined participation in our group. One further client had agreed to participate in the group but due to personal circumstances had to withdraw from participation. Another client had agreed to attend the group but in the end decided he did not wish to participate. This left a final N=5 for the group. Of these five, four participants attended all sessions with one drop out for the final two sessions due to a physical health difficulty.

The final group of five consisted of two females and three males. Four of them had received psychological help for their voices in previous years including CBT. The age range for the group was: 38- 74. Their mean duration of illness: 15.2 years. Four had diagnoses of Schizophrenia and one with Bipolar 1 disorder. Also present were three members of staff; a Psychiatric Nurse (P), Trainee Clinical Psychologist (Author) + Student Psychiatric Nurse.

The Weekly Group Structure

Working from the background literature above as well as that from the Hearing Voices Network the following six week schedule was developed. Each session consisted of one half hour, a fifteen minute tea break and another half hour. The aim was to provide a space to give some theoretical and practical information but to remain client led and not over prescriptive.

1. Introductions, ground rules & getting to know each other
2. Stress/vulnerability & identifying our own triggers
3. Some ideas of why people hear voices & do the ideas fit with my experiences?
4. Beliefs about voices & existing coping strategies
5. Beliefs about voices & developing more coping strategies
6. Review of coping strategies & group

See Appendix 4 - for greater detailed description of weekly group planned content.

Brief Description of Group members' Symptoms

The following is a brief and anonymised description of some of the key experiences group members relayed during the group.

A Started hearing voices some years ago. He had stress-panic attacks which were later substituted by voices. The voices were often of neighbours commenting negatively eg. “he should get a job”. The voices usually occurred in the evenings. *A* checked out and refuted beliefs in the past. He described feeling alone but that he copes OK. To cope he tries to think rationally and keep the voices for a certain time of day.

B’s voices started in childhood and have been diagnostically related to Bipolar Mania. In the past several voices have commanded him to hurt himself. He tends to have them most of the time, and finds them distressing although they are not always so harmful. Sometimes B feels he has to comply, but he is able not to at other times. B Feels anger & frustration with them. He copes with long walks, making plans and goals, keeping busy. Sometimes B punches the wall and the pain interferes with and reduces the voices.

C’s voices started 4 years ago. He feels they are linked to starting medication. He experiences several voices at any time of day. They are directive but not commanding. B described that he shouldn’t give them the time of day. He copes by ignoring, minimizing and/or bargaining with them.

D’s voices started 4 years ago. Although her voices have reduced in number, she describes them as a running commentary of her thoughts and actions. For her this is closely linked to a strange sensation in her mouth and tongue. She feels frustrated and powerless. She copes by ignoring the voices and just gets on with things, She likes to socialise.

E's voices started about twenty years ago. For her, the voices are nice in morning but turn nasty from afternoon onwards. When good, the voices help her to get things done, but as the day progresses they become more horrible and nasty. At these times E often feels frightened, vulnerable. E reported having other psychotic symptoms such as visual hallucinations. She coped by listening to music and watching television when they got bad.

Group formulation

We drew on an adapted stress vulnerability model as an explanatory tool for voice hearing (Nuechterlein & Dawson, 1984). Additionally, we tried to elicit other beliefs and theories around why people hear voices. The aim was to focus on the ability of group members to manage and adapt to their voice hearing and develop their own sense of strengths and coping styles (Davidson & Strauss, 1992; Place, 2003). Group members were also given small notebooks and encouraged to note down thoughts or content related to the voices they heard in order to begin monitoring their experiences.

The overall approach was structured into a CBT framework where, over the course of the six weeks, clients were encouraged to see links between their thoughts, feelings and behaviours and develop and explore the role in which cognitive appraisals played a part in the experience of voice hearing (Chadwick et. al. 2000b). See figure 1. below for a schematic version of the flip-chart work that the group developed. Boxes with downward arrows above them represent later coping strategies developed by group members themselves.

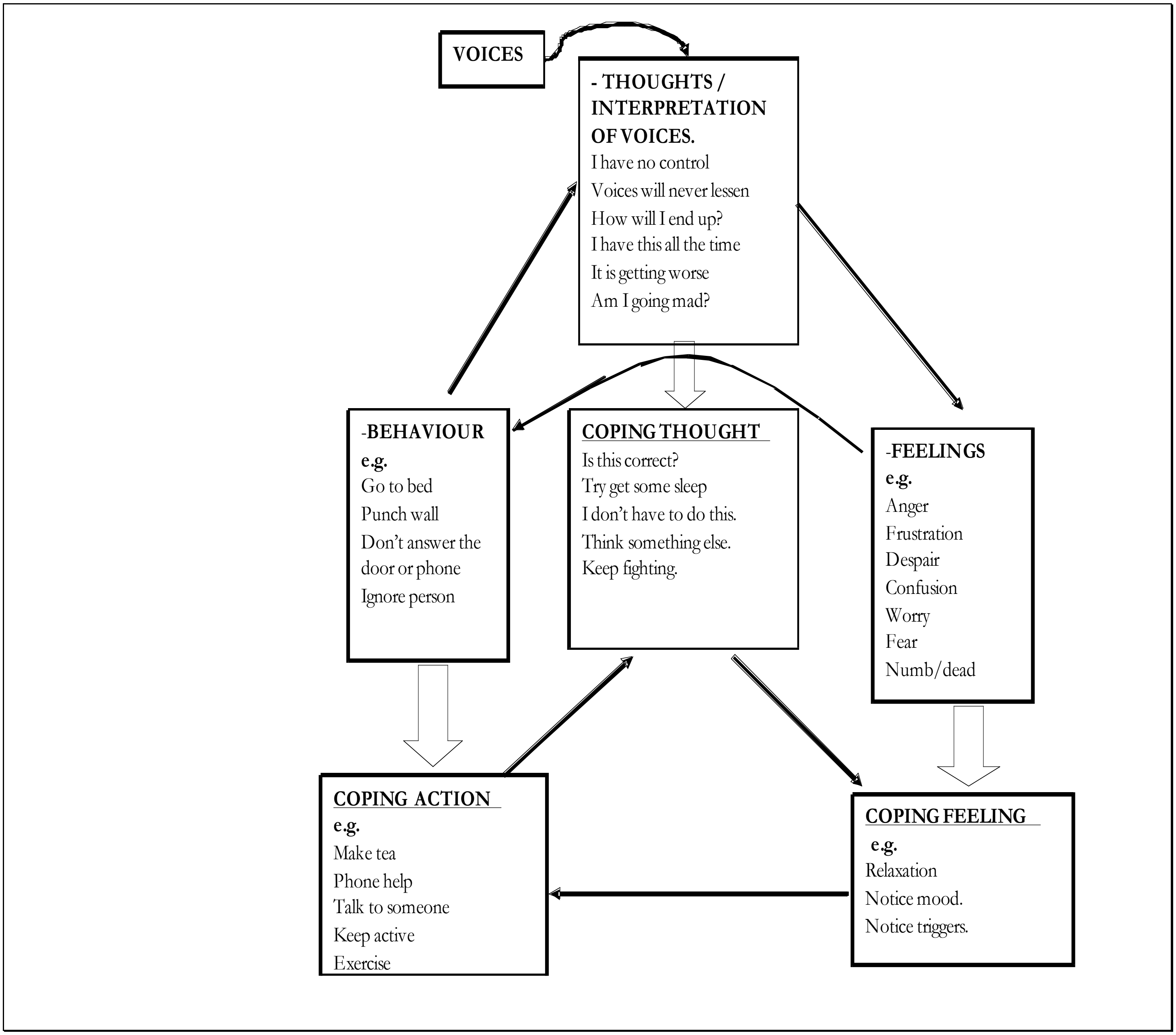

VOICES
- THOUGHTS / INTERPRETATION OF VOICES.
I have no control
Voices will never lessen
How will I end up?
I have this all the time
It is getting worse
Am I going mad?
-BEHAVIOUR
e.g.
Go to bed
Punch wall
Don't answer the door or phone
Ignore person
COPING THOUGHT
Is this correct?
Try get some sleep
I don't have to do this.
Think something else.
Keep fighting.
-FEELINGS
e.g.
Anger
Frustration
Despair
Confusion
Worry
Fear
Numb/dead
COPING ACTION
e.g.
Make tea
Phone help
Talk to someone
Keep active
Exercise
COPING FEELING
e.g.
Relaxation
Notice mood.
Notice triggers.

Figure 1. Group Formulation of difficulties and coping mechanisms.

RESULTS- Quantitative

The Visual Analogue Scale (VAS) data is presented below in Table 1. Scores for anxiety items such as being in the group and talking about voices showed an increase in reported anxiety for group members from pre to post measure. Conversely, items related to the degree with which voices were perceived to affect activities of daily living reduced from pre to post measure. There was also some increase in the participants' reported ability to minimize or reduce the negative aspects of their voices. Items on coping with voices and the ability to disagree or not with voices remained consistent from pre to post group measure. The small N of this group does not provide a basis for inferential statistics or significance testing.

	PRE-GROUP	MID GROUP	POST GROUP
ANXIETY TALKING ABOUT VOICES	20.4	56.6	37
VOICES AFFECT ADLS	61.2	60.4	46.3
I MUST DO WHAT VOICES SAY	31.6	37.2	31.8
I CAN DISAGREE WITH VOICES	62.4	51.6	66.5
I CAN COPE WITH VOICES	64.6	55	62.3
I CAN REDUCE BAD ASPECTS OF VOICES	42	44.8	48
ANXIETY BEING IN GROUP	21.2	29.8	38.3

Table 1. . Mean values for visual analogue scales (%) of 100mm.

The Revised Beliefs About Voices Questionnaire (BAVQII) consists of five sub-scales with a total of thirty five questions (See Appendix 7). Benevolence- the degree to which the hearer experiences the principal voice as warm or supportive. Malevolence-how negative and harmful the voice is felt to be. Resistance- the degree to which the client avoids or disregards the voice. Engagement- the degree to which the client seeks or engages with the voice and; Omnipotence- the degree to which the client feels they must do as the voice says.

Participants completed this questionnaire before the initial group and at the end of the final session. See Table 2. below. Each question was scored in a range from 0, 1, 2, 3 and sub-scale items were summed.

For Benevolence, clients reported a slight increase in the perceived positive qualities of the voices. For Malevolence, a decrease occurred in how negative the voices were perceived to be over the six week group. A similar increase of clients' reported ability to avoid or resist their voices was seen in the Resistance category. There was a relatively large decrease in the degree to which clients sought out or deliberately wished for their voices to speak to them in the Engagement category. Finally, their was also a more modest decrease in the degree to which clients felt that they must obey their voices in the Omnipotence category. Again, inferential statistical analysis was not performed due to the very small N.

	Mean Score 1	Mean Score 2	Mean Diff	% change
Benevolence	7.4	7.6	0.2	2.7
Malevolence	10.8	8.6	- 2.2	-20.4
Resistance	13.4	17	3.6	26.9
Engagement	8.4	4.7	-3.7	-44
Omnipotence	9.4	9.0	-0.4	-10.6

Table 2. Mean Scores and % change from Pre Group to final session for BAVQII

Results-Qualitative

Participants completed the eight-item feedback questionnaire. N=4, 1 Not able to complete. Responses were as follows, clients are in the order A, C, E, D (these letters refer to above client symptom descriptions on pp11-12) :

1. **Is the group what you expected?**

"Yes". "Yes". "Yes". "No".

2. **How have you found being in the group?**

"Interesting". "Interesting & Informative". "Alright, comfortable". "A bit of a struggle".

3. Has anything helped you?

"Yes" " Listening to others' experiences" "No, not a lot, but I like being in the group & you talking to me" "Different ways of coping with voices"

4. Has anything been unhelpful to you?

"No" "No" "No, nothing" "No"

5. Chances to speak and be heard by other group members?

"Yes" "Yes" "Yes" "Experienced a lot of voices that made it difficult to speak"

6. Rate the group from 1-10?

"8" "8" " 8" "5"

7. Making similar groups better in the future?

A- "More clients" E- "Nothing"

8. Any other comments?

C- "Thank you for running the group" A- "No, I appreciate what you've done for me. I realise the voices won't go away, but I know now that I'm not alone in hearing them" D- "Appreciate everyone's contribution"

Informal group member feedback

At the end of the group a final discussion took place to gain any further feedback that would be helpful for future groups. One client reported feeling a bit like ‘a guinea pig’ in that the therapists were not experts in Hearing Voices. Group members liked the halfway break, with tea & biscuits. They felt it helped with socialising. One client reported giving thought to reducing/stopping meds, and focusing on individual CBT for recovery. One client felt we had neglected social/family perspectives on client symptoms. Group members found using voice diaries difficult although one client had used his diary throughout.

Informal staff feedback

Reviewing the group, staff felt that planning time after each group had generally been taken up with debriefing key issues arising from group. Immediate pre-group planning had been perhaps too short. Further short planning meeting would have been beneficial. Staff had found that the groups didn’t always follow a strict plan, and it had been good being flexible. The clients had seemed to participate well reducing the need for staff facilitation. The student nurse who had sat in on the group to gain experience felt she had learned a lot from the groups and that she would be able to talk to clients about hearing voices in the future.

Dissemination

A presentation was arranged for the 29th September to the CMHT in order to feedback the results of the Voices Group. Present were two clinical psychologists, three nurses and a social worker. Psychiatry was not represented. Criticisms of the project were that it was not clear from the data the degree to which the participants had benefited. One psychologist reflected that qualitative analysis of transcript data would have led to a more detailed evaluation of the group. One worker agreed to liase with Nurse P in order for further groups to be done with a greater degree of communication within the CMHT. The possibility of carrying out the groups in the building of the CMHT was discussed to further increase engagement. It was felt likely that the group would continue on an annual or biannual footing and the present group and evaluation would serve as a point of departure for future hearing voices groups.

Discussion

Inferential statistical conclusions are clearly inappropriate from the available data due to the small number of group members. However, some key points are raised by the data.

The most worrying finding, from the VAS indicated that for group members the process of discussing their voices in the group setting might have been an anxiety provoking experience. This may reflect the very real difficulties faced in discussing such difficult experiences although intuitively a reduction in anxiety following exposure to discussion and group environment over six weeks might have been hoped for. However, six weeks may not have been long enough for such a process to occur. That the VAS may not be the best measure to tap into anxiety, and the fact that clients did not report concerns or anxieties during/between the sessions may undermine the idea that the group was somehow inherently anxiety provoking. One client did report the group to have been 'a bit of a struggle' on the feedback questionnaire although this may have been in relation to the immediate intrusion of voices that he reported experiencing during each of the weekly sessions.

More positively on the VAS the relatively high scores for coping and disagreeing with the voices, although not changing greatly from pre to post measure, may represent resilience factors in this group. This may be due to their experiences as well as earlier psychological and psychiatric interventions. The reduction in the impact on activities of daily living is an interesting finding particularly given the increase in reported anxiety. Anecdotally however, it should be stated that the VAS may have been difficult for participants to fill in due to scales being reversed to prevent repetition bias and as a result some error may be present.

The BAVQ II data although weak does support hypotheses regarding CBT and Hearing Voices. Each of the sub-scales shows modest changes in the direction hoped for by the facilitators of the group. Perhaps key, might be the modest reduction in the omnipotence of voices, something that is deemed to be crucial in ameliorating the negative consequences such as self harm due to voices (Chadwick et. al., 2000b). The largest reduction on the engagement and malevolence sub-scales, and increases in the resistance and benevolence scales may suggest a greater willingness from group members to challenge their voices and begin to experiment with new ways of doing so.

Critical Appraisal

Recruitment to the group

It was felt by the trainee (present author) and Nurse P that the CMHT, although interested initially, had not referred a great number of participants to the group despite the trainee attending several meetings and the project supervisor being a senior member of the team. This may simply be due to the timing of the group or the particular clients who were engaged with services at that time. Also it may be that a greater attendance by the trainee at weekly team meetings would have reinforced the request for referrals. Additionally, it may be that undertaking such a group within the CMHT building itself would serve to increase the profile of the group thus helping with the communication between professionals and particularly the recruitment of group participants.

Is six weeks long enough?

A recent RCT showed a cognitive behavioural approach to be modestly effective at increasing insight into symptoms of auditory hallucinations, although the authors state the 16 week programme of individual therapy may have been too short, Almaggia (2005). However, in another study, participation in both a seven and a twenty session group was associated with significant positive changes in the participants' beliefs about their voices with reduced negative reactions to the voices. Duration of treatment did not affect participants' beliefs or distress associated with the voices (Pinkham et.al 2004). Data at present may therefore be equivocal regarding the optimal number of sessions for voice hearers' groups. It is worth noting that the hearing voices network run ongoing groups which are evaluated in twenty week blocks. They feel this length allows for greater therapeutic alliance within the group as a whole, with an emphasis of moving toward a re-integration of the experience of voice hearing. Within the NHS it may not be possible or desirable to run such lengthy groups. However, lengthening the six week group e.g. for a further two sessions may allow for further integration and development of cognitive strategies and more elaborate formulations in future groups.

Evaluating The Group

The choice of Standardised, self developed quantitative measures as well as the open-ended qualitative measures was originally intended to capture as much diverse information as possible. Following from the limitations highlighted at the dissemination meeting regarding the ability to draw robust quantitative inferences from the data it may have been more beneficial to follow a more process orientated research paradigm. The scope of this project was always a limiting factor in which methodology to choose, but it may be that given these limitations a focused qualitative thematic analysis would better highlight the processes by which change in the group occurred.

CBT & Homework?

In line with much CBT work it was felt that homework may be useful (Addis & Jacobson, 2000) in facilitating the transfer of strategies and monitoring of voices outside of the session. To keep this as low key as possible, to avoid negative connotations of ‘homework’ this was referred to as optional work. Participants were given very small unobtrusive notepads in order to note down at any time they wished things they felt were relevant to the voices or content of the voices. Most participants did not engage with this activity, although one frequently noted down aspects of his voices. This participant, although reporting difficulty managing his voices, and difficulty talking about them, also was motivated to engage with cognitive formulations of voices.

Clients as 'guinea pigs'?

During the informal post group discussion, one client mentioned that to some extent he had felt like a 'guinea pig' for the members of staff getting used to running a hearing voices group. He felt that it may have been better to have an experienced or expert figure as part of the structure of the group. Our feelings were equivocal on this matter in that taking up the expert role does somewhat jar with a client led rationale which we felt was also beneficial. We were patently not experts in hearing voices, as we had not experienced such a phenomenon ourselves and positioning ourselves as such would have been arguably more problematic. Interestingly, a recent study of group CBT for psychosis showed improvement in social functioning but only the presence of experienced CBT therapists ameliorated hallucinations (Wykes et.al. 2005). These findings may be important for this specific service in the choice of facilitators for future groups, for example a trainee clinical psychologist or nurse, alongside an experienced and qualified psychologist. Arguably in our case, the facilitators (one of whom had experience of CBT in other group and individual settings) were closely supervised by the consultant clinical psychologist thereby serving to limit the criticism to some extent of lack of experience in providing CBT.

It is important also to note here that the HVN advocates that one facilitator should be a voice hearer themselves and thus providing legitimate expertise in a different way. This may be something which is easier to attain outside of the NHS setting in relation to honorary contracts/ expenditure and liability. In relation to both of these poles on the expertise continuum, it may be that a middle ground involving the recruitment of voice hearers as well as 'expert' clinicians as guest speakers could resolve some of the concerns whilst maintaining the advantages of the curious non-expert position that the current facilitators adopted.

Future plans

Of particular importance to this project was the provision of a platform from which nurse P could build resources and expertise in working with voice hearers and running subsequent groups. The development of knowledge of working with voice hearers generally and running an HV group specifically, had been an important learning curve for the nurse and trainee clinical psychologist. Balancing issues such as input into the group, expert vs novice positions, teaching versus open discussion had to be negotiated between the facilitators at each step. As someone identified within the service to deliver such groups on a periodic basis in the future it was particularly important for the nurse facilitator to develop and maintain links within the CMHT. Such links as the development of a proposed twice yearly 8 week group with an ongoing referral network were discussed in the dissemination meeting. Another worker at the dissemination meeting offered his support from within the CMHT by helping in the development of resources and expertise in subsequent hearing voices work. The supervising clinical psychologist agreed that supervision would continue to be made available from psychology within the CMHT and that co-facilitators from may be drawn again from the CMHT, and or trainee clinical psychologists from the local course. Future client specific groups (e.g. under 30’s, female & male, newly diagnosed etc.?) were discussed as possibilities although it was recognised this would depend on the needs of service users as they arose.

REFERENCES

Addis, M.E., & Jacobson, N.S., (2000) A Closer Look at the Treatment Rationale and Homework Compliance in Cognitive Behavioral Therapy for Depression. *Cognitive Therapy and Research, 24, 3, 313-326.*

Almaggia, L.R., Van der Gaag, M., Tarrier, N., Pijnenborg, M. (2005) Cognitive–behavioural therapy for refractory psychotic symptoms of schizophrenia resistant to atypical antipsychotic medication randomised controlled trial. *British-Journal-of-Psychiatry, 186, 4.*

American Psychiatric Association (1994) Diagnostic and Statistical Manual of Mental Disorders (4th edn) (DSM–IV).Washington, DC: APA.

Bentall, R.P., (2004) *Madness Explained; Psychosis & Human Nature.* Penguin Books, London.

Chadwick, P., Lees, S., Birchwood, M. (2000a) The Revised Beliefs About Voices Questonnaire. *British Journal of Psychiatry, 177, 229-232*

Chadwick, P., Sambrooke, S., Rasch, S., Davies, E. (2000b) Challenging the omnipotence of voices: Group cognitive behavior therapy for voices. *Behaviour-Research-and-Therapy. 38, 10, 993-1003.*

Curson, D., Barnes, T., Bamber, R., & Weral, D. (1985). Long Term Depot Maintenance of Chronic Schizophrenic Outpatients. *British Journal of Psychiatry, 146, 464-480.*

Davidson, L., & Strauss, J. S. (1992). Sense of self in recovery from severe mental illness, *British Journal of Medical Psychology, 65, 131 - 145.*

Drury, V., Birchwood, M., & Cochrane, R. (2000). Cognitive therapy and recovery from acute psychosis: a controlled trial. 3. Five-year follow-up. *British Journal of Psychiatry, 177, 8 - 14.*

Fleischhaker, W. W. (2002). Pharmacological treatment of schizophrenia; A review. In M. Maj & N. Sartorius (Eds.), *Schizophrenia* (2 ed., 75 - 113). Chichester: Wiley.

Gijswijt-Hofstra, M., & Porter, R., (eds.) (1998) *Cultures of Psychiatry and Mental Health Care in Postwar Britain and The Netherlands.* Clio-Medica, Amsterdam / Atlanta.

Haddock, G., Morrison, A. P., Hopkins, R., Lewis, S., & Tarrier, N. (1998). Individual cognitive-behavioural interventions in early psychosis. *British Journal of Psychiatry Suppl, 172, 33, 101-106.*

Harkavy-Friedman, J. M., Kimhy, D., Nelson, E. A., Venarde, D. F., Malaspina, D., & Mann, J. J. (2003). Suicide attempts in schizophrenia: the role of command auditory hallucinations for suicide. *Journal of Clinical Psychiatry, 64, 8, 871 - 874.*

Hearing Voices Network (2005): www.hearing-voices.org

Honig, A., Romme, M. A. J., Ensink, B. J., Escher, S. D. M. C., Pennings, M. H. A., & Devries, M. W. (1998). Auditory hallucinations; a comparison between patients and nonpatients. *Journal of Mental and Nervous Disease, 186, 646 - 651.*

Kuipers, E., Fowler, D., Garety, P., Chisholm, D., Freeman, D., Dunn, G., et al. (1998). London-east Anglia randomised controlled trial of cognitive-behavioural therapy for psychosis. III: Follow-up and economic evaluation at 18 months. *British Journal of Psychiatry, 173, 61-68.*

Morrison, A. P. (2002). *A casebook of cognitive therapy for psychosis.* Hove: Brunner-Routledge.

Morrison, A.P., & Haddock, G., (1997) Cognitive factors in source monitoring and auditory hallucinations. *Psychological Medicine , 27: 669-679*

Nuechterlein, K. H., & Dawson, M. E. (1984). A Heuristic Vulnerability-Stress model of Schizophrenia. *Schizophrenia Bulletin, 10, 300-312.*

Newton, E., Landau, S., Smith, P., Monks, P., Shergill, S., Wykes, T. (2005) Early Psychological Intervention for Auditory Hallucinations: An Exploratory Study of Young People's Voices Groups, *Journal of Clinical Psychology, Brief Reports , 193, 1, 58-61*

O'Neil, M., & Stockwell, G. (1991). Worthy of discussion; Collaborative group therapy. *Australian and New Zealand Journal of Family Therapy, 12, 4, 201 - 206.*

Pilling, S., Bebbington, P., Kuipers, E., et al (2002) Psychological treatments in schizophrenia: I. Meta-analysis of family intervention and cognitive behaviour therapy. *Psychological Medicine, 32, 763 –782*

Pinkham, A.E., Gloege, A.T., Flanagan, S., Penn, D.L., (2005) Group cognitive-behavioral therapy for auditory hallucinations: A pilot study. *Cognitive-and-Behavioral-Practice, 11, 1, 93-98.*

Place, C. (2003) Simple Coping Strategies for people who hear voices. *Nursing Times, 99, 47.*

Romme, M. A. J., & Escher, S. (1993). *Accepting Voices*. London: Mind.

Romme, M. A. J., & Escher, S. (2000). *Making sense of voices.* London: Mind

Slade & Bentall 1988 , Sensory Deception, The Johns Hopkins University Press
Simple Coping Strategies for people who hear voices. C. Place, *Nursing Times, 2003, 99, 47.*

Schermer, V. L., & Pines, M. (1999). Group Psychotherapy of the Psychoses: Concepts, Interventions and Contexts. London: Jessica Kingsley.

Tarrier, N., Haddock, G., Barrowclough, C., & Wykes, T. (2002). Are all psychological treatments for psychosis equal? The need for CBT in the treatment of psychosis and not for psychodynamic psychotherapy. *Psychology and Psychotherapy, 75, 365 - 374; discussion 375 - 369.*

Tien, A. Y. (1991). Distributions of hallucinations in the population. *Social Psychiatry and Psychiatric Epidemiology, 26, 287 - 292.*

White, J. R., & S., F. A. (2000). Cognitive-Behavioural Group Therapy for Specific Problems and Populations. Washington: American Psychiatric Association.

Wykes,T., Hayward, P., Thomas, N., Green,-N., Surguladze, S., Fannon, D., Landau, S., (2005) What are the effects of group cognitive behaviour therapy for voices? A randomised control trial Schizophrenia-Research., *British Journal of Clinical Psychology, 7, 201-210.*

Yalom, I. D. (1983). In-patient Group Psychotherapy. New York: Basic Books.

Appendix 1

Consent for Hearing Voices Group

The undersigned Trainee Clinical psychologist has explained the purposes for the use of using material from the Hearing Voices Group anonymously as the basis of a Research Project to be submitted to the University of Hertfordshire Doctor of Clinical Psychology Training Course for examination purposes.

I understand that even after giving my consent that I can withdraw consent at any time prior to submission. It has been made clear to me that it is totally up to me whether or not to give consent and that my decision will in no way affect the treatment I will receive, either currently or in the future.

Hearing Voices Group materials are treated as confidential records and are kept securely. All examiners on the course are qualified Clinical psychologists and are bound by the rules of confidentiality.

I have been assured that confidentiality will be preserved. I understand that all material written up in the Research Project will be totally anonymous. I have been advised that all identifying information will be removed including names, addresses, specific references and place references and any other information that may compromise my identity.

It is on this basis that I give consent for the basis of my psychological intervention and treatment to be used in the Research Project. I confirm that I have received a copy of this consent form.

Client Name (PRINT)____

Client Signature ____

Date ____

Name of Trainee Clinical Psychologist:

Signature ____

Date ____

Name of supervising Chartered Clinical Psychologist:
Contact Telephone Number:

Appendix 2
Assessment Interview Protocol (20mins)

1. Have you heard about the group? What do you know about it?

2. Give flyer-quickly review aims.

3. Referral form completed-Patient details?

4. Inclusion criteria
    - Are primarily distressed from hearing voices
    - Want to work as a member of a Hearing Voices Group
    - Usually have a diagnosis of psychosis/severe mental illness such as schizophrenia or affective psychosis
    - May have a contact who will liaise with the group facilitators, such as a care co-ordinator or key worker

5. Exclusion criteria
    - Present intoxication with substances such as alcohol, or drugs
    - Present extreme paranoid ideation which may be exacerbated by group work

6. Motivated to attend?

7. Administer questionnaires- If multiple voices (including good/bad) ask participant to focus on the worst voice.

8. Previous experience of groupwork?

9. What would you want from the group? What would you not want from the group?

10. Do you have any other questions?

11. Thankyou, we will send you a confirmation letter, dates and
map.

Appendix3

WE ARE ABOUT TO RUN A SUPPORT GROUP FOR PEOPLE WHO HEAR VOICES.

OUR AIMS WILL BE:

1. TO HAVE AN INFORMAL AND RELAXED GROUP, WITH TEA AND BISCUITS
2. TO LISTEN TO YOUR EXPERIENCES.
3. TO THINK ABOUT HOW/WHY PEOPLE HEAR VOICES.
4. TO DEVELOP WAYS TO REDUCE THE NEGATIVE IMPACT SOME VOICES CAN HAVE.

THE GROUP WILL BE FOR SIX WEDNESDAYS STARTING IN JUNE.

THERE WILL BE A NURSE (-------) AND CLINICAL PSYCHOLOGIST IN TRAINING (---------) TO RUN THE GROUP.

THERE WILL BE ABOUT SIX GROUP MEMBERS WHO ALSO HAVE EXPERIENCED HEARING VOICES.

IF YOU WOULD LIKE TO COME PLEASE SPEAK TO YOUR KEY WORKER TO ARRANGE A MEETING WITH --------- AND ----------.

Appendix 4

Hearing Voices Group

Weekly Structure

Week 1	**INTRODUCTIONS AND GROUND RULES (30min)**	**Tea Break 15min**	**OUTLINE OF THE GROUP AND GETTING TO KNOW EACH OTHER (30min)**
Week 2	**TRIGGERS AND OUTCOMES OF VOICES: Where & When? Stress/vulnerability (30min)**	**Tea Break 15min**	**IDENTIFYING OUR OWN TRIGGERS Where & When? (30min)**
Week 3	**SOME IDEAS OF WHY PEOPLE HEAR VOICES (30min)**	**Tea Break 15min**	**DO THE IDEAS FIT WITH MY EXPERIENCE OF VOICES? (30min)**
Week 4	**EXAMPLES OF PSYCHOSIS AND INTERPRETATION (30min)**	**Tea Break 15min**	**HOW DO WE INTERPRET OUR VOICES? (30min)**
Week 5	**BELIEFS ABOUT VOICES. Who & Why? (30min)**	**Tea Break 15min**	**COPING STRATEGIES: USING OUR INTERPRETATIONS AND BELIEFS ABOUT VOICES (30min)**
Week 6	**REVIEW OF COPING STRATEGIES (30MINS)**	**Tea Break 15min**	**REVIEW OF GROUP, QUESTIONNAIRES ANY FURTHER NEEDS THANKYOU (30min)**

Week 1	**Outline of the group and ground rules (30min)**	**Tea Break 15min**	**Group members experiences of voices (30min)**

OUTLINE OF THE GROUP AND GROUND RULES (30min)

Introducing ourselves- our names

- Group members as experts of their own experiences
- Facilitators as competent/interested professionals
- Rationale for group and research- i.e. to: share experiences, coping strategies (thoughts-emotions-behaviours)
- Group will help info for future groups
- Establish a relaxed and informal atmosphere
- Hearing voices- recent advances in knowledge include:

2% general population hear voices.

5 main types of voices:

Insults, Friendly, command, 3rd person commentary, whispers

1/3 voice hearers find it distressing.

Distress makes it harder to cope with voices.

Ground rules (5mins) to include:

- Try to attend
- Respect each other
- Confidentiality
- Listen to each other
- Give everyone a chance to speak/ try not to interrupt
- Non-judgemental attitude
- No aggression-verbal abuse
- Time out option.
- Have a tea break each week

Group members experiences of voices (30min)

Aims include:

- Establishing when voices started (some prompt questions):

How many?- more or less than before?

Good/bad/both?

What triggers them?

What do they say?

Do you have an explanation for how you got them?

What impact do the voices have on your life?

What helps you to cope?

Thinking strategies- dismissing, ignoring, listening, selective listening, distraction with other thoughts, boundaries, making a deal?

Behaviour strategies- being active, speaking to someone, leaving/going somewhere, writing, routines/rituals?

Feeling strategies- negative tension release, drugs, alcohol, self harm-positive tension release- exercise, yoga, soft drink, bath,time alone, relaxation, sleep,etc.

- Introducing the diary:

Useful to notice thoughts and emotions related to voices

Don't worry if you are not able to write much

If voices are constant, note down times when they are reduced in number, loudness, nastiness and what is happening at same time.

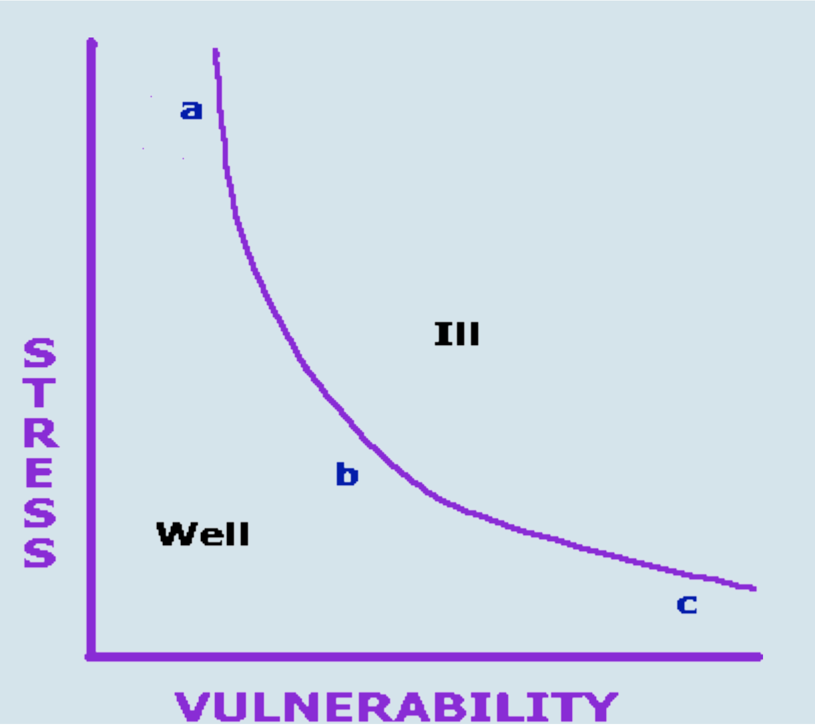
Try to do it when you notice/remember, not at the end of the day.

Homework 1: Start the diary

Week 2	STRESS VULNERABILITY & TRIGGERS (30min)	Tea Break 15min	IDENTIFYING OUR OWN TRIGGERS Where & When? (30min)

STRESS VULNERABILITY & TRIGGERS (30min)

Stress/vulnerability



Individuals have unique biological, psychological and social strengths and weakness including strengths and vulnerabilities for dealing with stress. Above, person "a" has a very low vulnerability and consequently can withstand a huge amount of stress, however solitary confinement may stress the person so much that they experience psychotic symptoms. Person "b" in the diagram has a higher vulnerability, e.g. due to genetics. Person "c" also has genetic loading but also suffered early negative life events. Here, persons "a" and "b" take more stress to become "ill". Increasing coping skills or altering environmental factors (family, work, finance, housing etc.) and judicious use of anti-psychotic medication can reduce vulnerability and build resilience. Attending the hearing Voices group may help to build self-efficacy, self-esteem and self-acceptance all of which may be protective against relapse and forms a buffer to demoralisation

Triggers can be…

- Case example: A.G. p125-126-128 (Romme&Escher 1994)

Places
Situations
Times
People
Objects
Thoughts
Feelings

Easier to cope if you can:

- See yourself as 'stronger' than the voices
- Experience more positive voices
- Experience less imperative (commanding) voices
- Set more limits to voices
- Listen selectively to voices
- Communicate more often about the voices with trusted others

WHAT TRIGGERS YOUR VOICES and HOW DO YOU COPE? (30min)

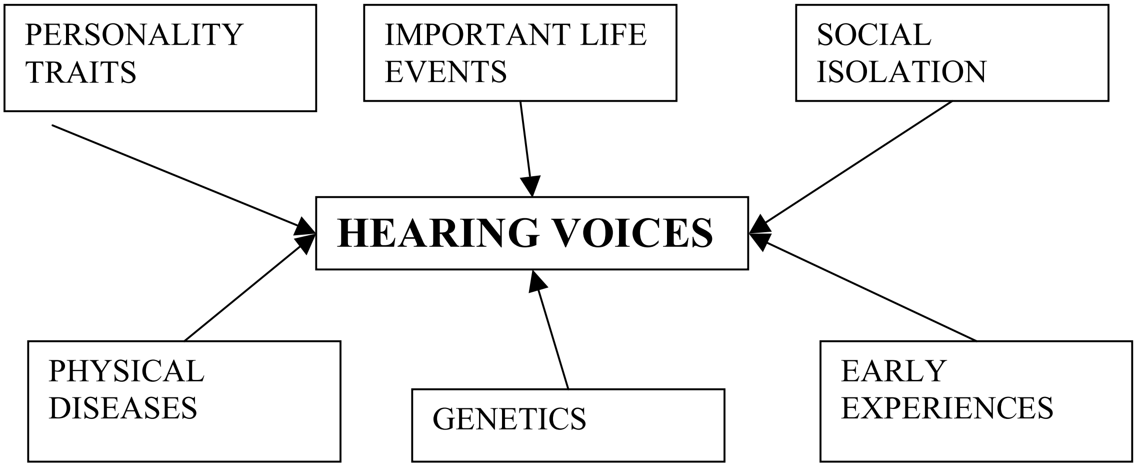
- Use diary to help to look for stressors/themes/patterns?
- The people in our lives, when alone, when with others generally or in certain people in particular?
- Situations: Work, Supermarket, Pub, at home, outside?
- Times: Mornings, Afternoon?
- Good and/or bad voices?
- Looking at some of the possible stressors that may have occurred at the same time?
- And voice-free time?

Homework 2. Diary-voices & triggers when & where?

Week 3	**SOME IDEAS OF WHY PEOPLE HEAR VOICES (30min)**	**Tea Break 15min**	**WHAT IS THE IMPACT OF THE VOICES ON GROUP MEMBERS NOW? (30min)**

SOME IDEAS OF WHY PEOPLE HEAR VOICES
(30min)

- Nobody knows for sure, only theories
- Stress vulnerability model
- Information processing- ‘filter theory’
- Voices as symptoms of PTSD (70+% history of trauma) Traumatic memory not necessarily verbal/ accessed at will/ useful/ dissociated experiential state
- Expressed Emotion
- Dissociation- looking down on things
- Model: Past events-personal beliefs- behaviour and symptoms
- Group members’ thoughts?


PERSONALITY TRAITS
IMPORTANT LIFE EVENTS
SOCIAL ISOLATION
HEARING VOICES
PHYSICAL DISEASES
GENETICS
EARLY EXPERIENCES

WHAT IS THE IMPACT OF THE VOICES ON GROUP MEMBERS NOW?
(30min)

-Emphasise rationale for diary. Anything from the diaries?

Everyday activities?

- Work?
- Friends/social?
- Personal care?
- Holidays or timeout?

Physical & Psychological

- Sense of well being? Sense of fun/humour?
- Eating/diet?
- Confidence/self-esteem?
- Mood?
- Sleep?
- Concentration/memory?

Homework 3. Continue using the diary and noticing aspects of the voices.

Week 4	EXAMPLES OF VOICES AND INTERPRETATION (30min)	Tea Break 15min	FOCUS ON COPING STRATEGIES. VOICE FOCUSED AND STRESS FOCUSED (30min)

EXAMPLES OF PSYCHOSIS AND INTERPRETATION (30min)

- CBT
- Cat downstairs story
- Voice hearers examples related to CBT
- Who, why, where, when?
- Omnipotent?
- Is the voice angry, happy, sad, vindictive?
- Am I feeling any emotions?- what are they?
- How do we interpret our voices?

FOCUS ON COPING STRATEGIES. (30MINS)

Strategies arising from the group.

Homework 4. Diary-what are some of my beliefs about my voices?

Week	HOW DO WE	Tea	COPING STRATEGIES:

5	**INTERPRET OUR VOICES? (30min)**	**Break 15min**	**USING OUR INTERPRETATIONS AND BELIEFS ABOUT VOICES (30min)**

HOW DO WE INTERPRET OUR VOICES? (30min)

- When do they start or stop?
- Who are the voices?
- Good or bad?
- Why now?
- Fear and voices? What will they make me do?
- How much control do I have/ do I have any?
- Questions we can ask

What is the impact of hearers on their voices?

- Can you turn the voices on? How?
- Can you turn the voices off? How?
- Can you make the voices louder? How?
- Can you make the voices quieter? How?
- How can the content of the voices be challenged?

COPING STRATEGIES: USING OUR INTERPRETATIONS AND BELIEFS ABOUT VOICES

(30min)

Focusing on the interpretation
Using the diary, when?,where? Stressed out? I don’t need to comply, I am in control not the voice

Using the content
Questioning, writing it down, check with a friend, let someone know.

Distraction

- ‘Time-share’ with the voices-let them speak at a certain time of day only
- TV, Music, Exercise or activity, Bath, Relaxation, ignoring, looking after self, having fun, doing something nice/interesting

Homework 5. Diary- things I’ve done to cope this week.

Week 6	**REVIEW OF COPING STRATEGIES**	**Tea Break 15min**	**REVIEW OF GROUP, QUESTIONNAIRES ANY FURTHER NEEDS THANKYOU (30min)**

REVIEW OF COPING STRATEGIES
(30min)

Focusing on the interpretation
Using the diary, when?,where? Stressed out? I don't need to comply, I am in control not the voice

Using the content
Questioning the voice (outloud or quietly), check with a friend, let someone know.

Distraction
- 'Time-share' with the voices-let them speak at a certain time of day only
- TV, Music, Exercise or activity, Bath, Relaxation, ignoring, looking after self, having fun, doing something nice/interesting

REVIEW OF THE GROUP, QUESTIONNAIRES & IDENTIFYING ANY FURTHER NEEDS (30min)

BAVQ-R
VISUAL ANALOGUE
EVALUATION FORM

Homework 6. Diary- when & where? How did I feel?
Keep going…

THANKYOU

Appendix 5

Some thoughts on hearing voices

Put a mark on the line that is closest to how much you agree with each sentence. For example:

I enjoy eating food

Not at all 0	Completely 100

Start.

I am anxious about the group

Completely 100	Not at all 0

I am anxious when talking about hearing voices

Not at all 0	Completely 100

My voices affect my everyday living

Completely 100	Not at all 0

I must do what my voices tell me

Not at all 0	Completely 100

I can disagree with my voices

Completely 100	Not at all 0

I can cope with my voices

Not at all 0	Completely 100

I can reduce the bad aspects of my voices

Completely 100	Not at all 0

End.

Thankyou for completing this questionnaire.

Appendix 6

EVALUATION QUESTIONNAIRE-HEARING VOICES GROUP

We were wondering if we could get some feedback from you about how you have found the group.

1. Is the group what you expected?
2. How have you found being in the group?
3. Has anything in the group helped you?
4. Has anything in the group been unhelpful to you?
5. Did you get chances to speak and be heard by other group members?
6. How would you rate the group from 1-10? One being the worst score, ten being the best score.
7. What would make similar groups better in the future?
8. Any other comments?

Thankyou for taking the time to fill out this form

Childhood Sexual Abuse and its Relationship to Adult Psychopathology- Literature Review

Nathan O'Neill

Cohort 4

Student I.D. 04080689

Word Count - 4910

Introduction

This literature review seeks to gather together what we know about the effects of childhood sexual abuse. The predominant focus will be on the psychopathology of adults who have been sexually abused in childhood.

Firstly, a brief consideration of some of the various definitions of childhood sexual abuse will provide a basis for understanding the field. This will be followed by a discussion of the available data on prevalence and incidence of childhood sexual abuse in order to gauge the size of this problem both internationally and in the UK.

Next, consideration will be given to the current evidence base that outlines the importance of investigating the psychological aspects of childhood sexual abuse. There is now considerable evidence that indicates significant negative psychological implications of childhood sexual abuse in adults. This will then lead onto an exploration of some of the key psychological models/theories that have attempted to account for the development of psychological dysfunction in adults who have been abused as children. This review will also briefly consider recent literature on the efficacy and effectiveness of psychological therapies for adult survivors of childhood sexual abuse.

Finally, we will consider social constructionist perspectives and issues within recent literature regarding psychological knowledge about childhood sexual abuse and its psychopathological correlates. This is hoped to provide a space within which critical thinking about the topics raised in this review might occur. (See Appendix 1 for Electronic Literature Search Audit).

Definitions of Child Sexual Abuse

Sexual abuse of children has been defined as any act that involves sexual molestation or exploitation of a child by a parent or other person who has permanent or temporary care, custody or responsibility for a child or is simply in contact with a child regardless of whether physical injuries are perpetrated (Furniss,1991; Doyle, 1994; Finkelhor, 1986; Glaser & Frosh, 1988). This can include the removal of a child's clothing, sexual touching, or sexual relations between people who are different in age and power, both physically and psychologically (Bentovim, 2002; Finkelhor et.al., 1990). Sexual buse has also been defined as any activity which involves children in which the perpetrator expects to achieve sexual gratification (Baker & Duncan, 1985; WHO, 2002).

Sexual abuse also refers to any adult's (person over eighteen years of age) sexual behavior with those under the age of sixteen years, which is prohibited by law in the United Kingdom. This includes: sexual activity with a child, in the presence of a child and causing or inciting a child to engage in sexual activity (Home Office, 2006). Addtionally, The Sexual Offences Act 2003, which came into force in May 2004 introduced that children under the age of thirteen years of age can now never legally consent to sexual acts (Home Office, 2006).

Sexual abuse may often involve physical trauma that is not easily visible such as cuts of the genitalia, urinary infections, or sexually transmitted diseases (DeVoe & Faller, 2002). Many survivors recall multiple sexually abusive acts including forced anal penetration, oral-genital contact, manual stimulation, and exhibitionism as well as physical violence and abuse. Indeed, sexual abuse is often accompanied by physical and emotional abuse (Holmes & Slap, 1998; Polusny & Follette, 1995, Fergussen and Mullen, 1999).

Very often the child who is being sexually abused is manipulated by trust, coercion, violence or threat of physical violence (Finkelhor, 1986). Child sexual abuse is therefore frequently a massive violation of a child's psychological well-being and is a massive violation of a child's basic rights. Child Sexual Abuse frequently results in a disruption or alteration of a child’s physical and or psychological development (Beitchman, 1991). It has been strongly associated with a range of negative mental health outcomes in both children and also in later adulthood (Fergusson et. al. 1996). These often include a range of psychological disturbances and will be discussed below.

Childhood sexual abuse – Prevalence & Incidence Internationally

A number of studies highlight the importance of definitions of sexual abuse and information procurement methods when comparing international figures (Gorey & Leslie, 1997; Martin et al 1993; Creighton, 2002; and Fergusson and Mullen, 1999). This should be taken as an important caveat before weighing the relative figures of different countries.

Finkelhor (1994), in his frequently cited overview of child sexual abuse surveys in 21 countries, concluded that the different ways in which child sexual abuse was defined in each country made cross-country comparisons largely impossible. However, Finkelhor (1994) also noted that childhood sexual abuse was of world-wide concern and of significant proportions.

Prevalence refers to the proportion of a defined population who have been abused during a specified time period. From prevalence studies, Finkelhor (1994) reported international prevalence rates for childhood sexual abuse in the range of 7-36% for females, and 3-29% for males. Most of these studies found females around 1.5 – 3 times more likely to suffer childhood sexual abuse (Finkelhor 1994). He also reported that the wide variation in national prevalence rates (e.g. 27% in the United States' female population compared with for 12% in the UK) to be largely due to the variation in sampling and interviewing procedures of the different studies and therefore not a reflection of actual differences. Other Childhood sexual abuse prevalence studies include Pilkington and Kremer (1995), Fergusson and Mullen (1999) and Tonmyr (1998).

Lampe (2002) conducted a survey looking at incidence rates in Europe only. Incidence refers to the number of new cases occurring in a defined population (in this case children) over a year. Lampe (2002) found that incidence of Childhood sexual abuse for individuals under the age of sixteen years was 6%-36% for females and 1%-15% incidence in males. A huge variation in ranges.

Both Finkelhor (1994) and Lampe (2002) highlighted that prevalence and incidence studies have mainly been conducted in western countries and that comparisons between countries should be treated with caution because of the different definitions and study methods employed. One further common finding of note in the literature is the difference in rates of abuse in boys and girls of about 1:3. This may be due to under-reported abuse in boys as well as being the case that females are generally more likely (on average) to be abused than boys (Ackard & Neumark-Sztainer, 2003; Holmes & Slap, 1998; Molnar 2001).

Childhood sexual abuse – Prevalence & Incidence-UK Figures

Finkelhor's (1994) study reported a prevalence rate of childhood sexual abuse of twelve per cent in females and eight per cent in males in the United Kingdom. Of these figures fourteen per cent occurred within the family in the case of females, and thirteen per cent within the family in the case of males (Finkelhor, 1994) based on household interviews with around two thousand participants.

In a further study carried out by the National Society for the Prevention of Cruelty to Children (NSPCC) Cawson et al. (2000) provided a robust and fine grained analysis of the experiences of just under 3000 young adults in the UK. Highlighting the importance of providing clear definitions of childhood sexual abuse, Cawson et al. (2000) defined it as: those who were aged 12 or under (regardless of consent) at the time of sexual activity as well as those who had not consented to sexual activity under age sixteen. On these definitions they found about 1% of the total sample had been sexually abused by parents/carers, almost always involving physical contact. In addition, around 3% of the overall sample had been abused by other relatives (of which 2% was contact and 1% non-contact abuse). Finally, around eleven per cent (11%) of the total sample had been sexually abused by other known people (of which 8% was contact and 3% non-contact abuse), (Cawson et.al., 2005).

Cawson et.al.'s (2005) total figure of around fifteen per cent (15%) is also in rough accordance with UK government statistics regarding children's names added to child protection registers during the years 2001-2006 across the UK. Of these about roughly 10-15 percent across each nation and year were deemed to have been sexually abused (See Appendix 2). Although the Cawson (2005), Finkelhor (1994) and Lampe (2002) figures suggest that those children on the child protection register may be a smaller fraction of an actual undetected prevalence rate.

Childhood sexual abuse and Adult Mental Health Problems

The literature to date on childhood sexual abuse suggests a wide range of mental health problems as being more likely to occur in those who have been sexually abused as children compared with the general population.

For instance, in the U.S. Molnar et. al. (2001) found a reported rate of 13.5% of women and 2.5% of men had been abused. Of these, after controlling for other childhood adversities, significant associations were found between childhood sexual abuse and the later onset of fourteen mood, anxiety, and substance use disorders in women and 5 disorders among men. Within this data, Molnar (2001) reported an increased likelihood of developing depression and substance problems for women if the abuse had been characterized by particularly; rape, repeated abuse and abuse by a known perpetrator. Some of the reasons for these factors increasing a likelihood of developing mental health problems will be discussed in the below section on mediating processes.

People who report abuse where there was physical contact or penetrative sexual acts in childhood have been found to have double the normal rates of mental disorders and suicide attempts compared with that found in the general population (Fergusson et al. 1996). These researchers also suggested that 11% of depression in women and 3% of depression in men could be attributed to contact or penetrative abuse in childhood (Fergusson et al. 1996). Further studies have found that adult survivors of sexual abuse frequently report higher rates of general psychological distress. This may include psychiatric disorders such as anxiety and depression as well as dissatisfaction with sex and/or high-risk or dysfunctional sexual behavior (Polusny & Follette, 1995; Heger et al., 2002).

Chaffin et al (2005) found that the risk in children for developing new anxiety disorders after the onset of sexual abuse showed a positive dose–effect. That is, the more severe the abuse the greater the likelihood of developing an anxiety disorder. This links with Macmillan et al. (2001) who studied just over seven thousand residents aged from 15 to 64 years of age. They found that women in particular who reported a history of childhood sexual abuse were associated with higher rates of psychological disorders. In men, the prevalence of disorders among those who reported exposure to sexual abuse was associated particularly with the development of alcohol abuse or dependence, perhaps mirroring or providing a sub-component of broader trends in the depression literature (Piccinelli, 2000). Overall, Chaffin et al (2005) concluded that childhood history of abuse increases the lifetime risk of psychopathology particularly in women. Interestingly, this may be subject to the under-reporting of childhood sexual abuse in males and severity of abuse in females as reported above. Further studies have found childhood sexual abuse to be associated with the development of serious mental and physical health problems, substance abuse, victimization, and criminality in adulthood (Widom 1994, Putnam 2003, Fergusson et al. 1996, Nelson et al. 2002).

Over the past decade there has emerged an increasing amount of evidence that childhood trauma including childhood sexual abuse are significant risk factors in developing adult psychosis (Read, Agar, Argyle & Aderhold, 2003: Morrison et. al 2003 : Larkin & Morrison 2006). In one particularly stark set of findings individuals who had suffered severe childhood sexual abuse were found to be forty eight times more likely than in the general population to later experience 'pathology level' psychosis (Jaansen, 2004). However, this association was not supported in a British study by Spataro et.al. (2004) whose own study although robust in general had several key limitations in relation to Schizophrenia, including the sample being drawn from adults up to the age of twenty years (just prior to peak age of onset in Schizophrenia) who had been removed from their abusive environments and therefore represented a relatively protected sample.

Outside of the psychoses, Spataro et. al. (2004) study also lent support to the hypothesis that childhood sexual abuse is a significant risk factor in several domains of adult psychopathology. They particularly highlighted childhood sexual abuse as a significant risk factor in the development of Personality Disorders in adults. This assertion has widespread support in the psychiatric literature and will also be discussed below within a social constructionist context.

In relation to this, Laporte & Guttman (1996) reviewed over seven hundred psychiatric records of female patients aged sixteen to forty five years with a discharge diagnosis of personality disorder and examined background variables such as loss; verbal, physical, and sexual abuse, witnessing domestic violence; and parental drug or alcohol abuse. They found that women with diagnoses of borderline personality disorder (BPD) reported having experienced more losses and abuse than women with other types of personality disorder. Also when abused women with BPD suffered more combined abuse at the hands of multiple perpetrators. In addition, some ninety three per cent of those with diagnoses of BPD had experienced at least one form of separation or abuse in childhood compared with seventy four per cent of the women with other personality disorders (Laporte & Guttman, 1996).

Processes Mediating Childhood sexual abuse and Adult Mental Health Problems

Twenty years ago, Finkelhor (1986) set the seen for research into and understanding of childhood sexual abuse in the late 20th Century. In addition to his influential research into international prevalence rates he proposed four key abuse dynamics or relations that might operate between a child and an abuser. These 'Trauma-genic Dynamics' (Finkelhor, 1986, p186) describe theoretical processes by which the experience of being sexually abused as a child might manifest itself in terms of psychological and behavioural sequelae. Additionally they may set the seen for subsequent development of adult psychopathology. Briefly the dynamics are: Traumatic Sexualization, Stigmatization, Betrayal and Powerlessness.

'Traumatic Sexualization' refers to a process whereby a child is rewarded for developmentally inappropriate sexual acts and may develop misconceptions regarding sex. Sex may be conditioned to have negative emotions and memories attached to it. This may lead to increased salience of sexual stimuli and to confusion regarding sexual identity and norms. It may also lead to confounding intimacy with sex, promiscuity, prostitution and sexual dysfunction.

'Stigmatization' occurs when an abuser blames, denigrates or ridicules a child but also pressures them to secrecy. Others may have a shocked and /or disgusted reaction and blame the child if the abuse is uncovered or disclosed. This may leave the child with a sense of being 'damaged goods' (Finkelhor 1986, p186). This in turn may lead to feelings of guilt or shame in the child with low self esteem and a sense of isolation from others. It may also be implicated in substance misuse, self harm and suicide.

‘Betrayal’ describes a dynamic process whereby the child’s sense of trust is violated. This both in terms of a child feeling betrayed by an abuser or by those who could or should have acted to protect the child. Psychologically this may lead to grief and depression, deep mistrust of others and anger and hostility towards others (Finkelhor 1986, p187).

‘Powerlessness’ may arise from the invasion of the child’s physical and psychological space by the abuser. Also from the inability to defend oneself from a more powerful figure; being subject to force and or deceit and not being able to halt the abuse. It may also arise out of a difficulty or inability to convince others of the existence of the abuse. Psychologically this may lead to anxiety, fear and a diminished sense of self efficacy. Behaviourally it may manifest in phobias, nightmares, somatic complaints, eating and sleeping disorders, dissociation, school difficulties and refusal, vulnerability to subsequent victimization or substance misuse (Finkelhor 1986, p187).

These themes although not empirically validated by Finkelhor himself have found support in subsequent literature and may thus serve as important stepping stones in considering how and why sexual abuse might lead to adult psychopathology. Katerndahl et al. (2005) identified predictors of resilience and adult mental disorders in women with a history of childhood sexual abuse. This cross-sectional study looked at adult female patients attending a family centre, aged between eighteen and forty years. They found around seventy-six percent of the women met criteria for at least one adult psychological disorder. Conversely, good mental health was related to high socio-economic status, lack of family alcohol abuse, lower frequency of first perpetrator abuse, and fewer perpetrators. Whereas specifics of the abuse such as immediate familiality, higher frequency and earlier age of onset were also associated with development of borderline personality disorder, substance abuse, major depressive episode, suicidality, bulimia, agoraphobia, and panic disorder (Katerndahl et.al, 2005).

In a qualitative study of male survivors of childhood sexual abuse designed to elicit more process related information Lisak (1994) conducted autobiographical interviews with twenty six adult male survivors. It was found that roughly equal numbers of men had been abused by male and female perpetrators, almost half came from disrupted or violent homes and a majority had a history of substance abuse. Fifteen psychological themes were identified: anger, betrayal, fear, homosexuality issues, helplessness, isolation and alienation, legitimacy, loss, masculinity issues, negative childhood peer relations, negative schemas about people, negative schemas about the self, problems with sexuality, self blame/guilt and shame/humiliation.

One strand of thinking that may link the presence of traumatic events in childhood and the emergence of adult mental health problems may be those psychological processes implicated in separation of the individual from the pain of traumatic event/s intra-psychically. This might be couched in terms of a kind of ‘forgetting’ or dissociating from the traumatic abuse events. In the 20th Century, Freud (1953-1974) proposed that unwanted memories could be kept out of conscious awareness by a process he called repression. These ideas were related by Freud to sexual abuse as he uncovered a number of cases in his clinical practice. His conclusions opened a hugely fierce and controversial clash of theories and evidence regarding both the validity of concepts such as repression; of false or recovered memories and psychotherapeutic responses to sexual abuse in general (Cioffi, 1974; Masson, 1984, Borch-Jacobson, 1996).

Until recently however, it has remained unclear how a process such as repression might occur in the brain. In the 21st Century, Anderson et. al. (2004) used functional magnetic resonance imaging (fMRI) to identify neural systems that may be implicated in keeping unwanted memories out of conscious awareness. They found that the control of unwanted memories was associated with increased dorsolateral prefrontal activity, reduced hippocampal activity, and reduced retention of those specific memories. They found that prefrontal cortical and right hippocampal activations predicted the amount of forgetting of these memories in their subjects. These results provided evidence for the existence of an active forgetting process that might lead inquiry into how motivated forgetting can occur. But how might such findings relate to more clinical populations?

Foote et al. (2006) undertook research to assess the prevalence of dissociative disorders in an inner-city outpatient psychiatric population. Self report questionnaires and structured interviews completed by just over eighty men and women revealed dissociative disorder in twenty nine per cent of patients. They found that six per cent of the patients satisfied criteria for Dissociative Identity Disorder. Additionally, the patients with a dissociative disorder, compared to the patients without, were significantly more likely to report having suffered childhood sexual abuse (74% versus 29%), The dissociative and non-dissociative groups did not differ significantly on any demographic measure, including gender (Foote et.al. 2006).

In a related study, Kisiel et al. (2001) found Sexual abuse history was significantly associated with dissociation. Both sexual abuse and dissociation were independently associated with several indicators of mental health disturbance, including risk-taking behavior (suicidality, self-mutilation, and sexual aggression). Severity of sexual abuse was not associated with dissociation or psychopathology. Dissociation may therefore be a critical mediator of psychiatric symptoms and risk-taking behavior among sexually abused children and adolescents. This study raised therefore that the assessment of dissociation among abused children may be an important aspect of early interventions.

In a different study Romans et al. (1999) found no connection between dissociation and childhood sexual abuse. They looked into the psychological coping styles of around three hundred women half of whom had reported childhood sexual abuse. They found that the women reporting childhood sexual abuse showed what they termed ‘more immature defense styles’ which comprised: rationalization, autistic fantasy, displacement, isolation, dissociation, devaluation, splitting, denial, passive-aggression, somatization, acting out, and projection. They also found that women who had experienced the most severe childhood sexual abuse showed the greatest prevalence of immature coping styles. Although Romans et al (1999) did not find a link with dissociation this may have been due to the non-clinical population from which they drew their sample. However their study does indicate an important role played by coping styles as a major mechanism through which childhood sexual abuse may increase rates of later psychological problems.

Childhood sexual abuse has also been hypothesized as leading to mental health problems because it impacts negatively with the process of attachment. This may be result in an impairment of an individual's emotional regulation, through exposure to prolonged and major stress (De Bellis et.al 1994; Schore, 2003). Katerndahl et.al, (2005) also highlighted that the family environment was strongly implicated in the reactions to childhood sexual abuse including the development of adult psychopathology.

Alexander (1992) argues that research on sexual abuse frequently fails to address the influence of the family as a risk factor for the onset of different types of sexual abuse and as a mediator of its long-term effects. Attachment theory provides a useful conceptual framework for understanding the familial antecedents and long-term consequences of sexual abuse. In addition it may be a conceptual framework for tying together evidence relating personality disorders, dissociation, and trauma.

Alexander (1992) also argues that the difficulties that are associated with insecure parent-child attachment such as rejection, reversal of roles, parentification of a child, fear and unresolved traumatic experiences are often situated within relationships of families characterized by sexual abuse. In this respect Alexander returns to Finkelhor's (1986) concepts of traumagenic dynamics but adds the attachment style that an individual may take with them into other future relationships.

This raises a further issue regarding the processes involved in the implications for adults' psychopathology after childhood experiences of sexual abuse. Carter & Prentky (1990) estimated that as much as fifty seven percent of sexual abusers had been sexually abused themselves as children. It has been hypothesized that some victims of childhood sexual abuse become abusers themselves due to their difficulties in relating to people outside of a non-sexualised relationship (Bagley et.al 1991, 1994).

In support of this, Lisak et. al (1996) assessed six hundred men from a non-clinical population. They found that eleven per cent of the men reported having experienced sexual abuse. With a further seventeen per cent reporting physical abuse alone. Another seventeen per cent reported having experienced both sexual and physical abuse. Of the 257 men in the sample who had reported experiencing any form of childhood abuse, almost forty per cent reported themselves to have acted out some form of abuse on another, thus echoing Carter & Prentky's (1992) study. These men were also measured as being more rigid in their views about gender and less expressive of their emotions. In contrast, Men who reported abuse but not perpetration demonstrated significantly less gender rigidity, less homophobia and less emotional constriction than non-abused men who perpetrated abuse. This finding may echo Roman's et. al.'s (2005) work with women by implicating an important role played by individual coping styles at multiple levels of abuse, psychopathology and risk.

Childhood Sexual Abuse and Psychotherapy Outcomes

Peleikis et.al. (2005) examined the mental health status of women with a history of child sexual abuse who had received outpatient psychotherapy for anxiety disorders and/or depression. At five year follow up after receiving outpatient psychotherapy, a hundred and twelve females were interviewed, half of whom had experienced child sexual abuse. Among the sexually abused women ninety five per cent still had a mental disorder. This was in contrast to around seventy per cent of women with no history of childhood sexual abuse meeting criteria for psychological disorders.

In contrast, Price et. al (2001) reviewed eight studies spread across four separate psychotherapy orientations. These were Cognitive-Behavioural, Psychodynamic-Interpersonal, Experiential and Psycho educational-Supportive. Across all of these psychotherapy interventions, Price et. al. (2001) found support the effective use of individual psychotherapy for adult survivors of childhood sexual abuse. Significant findings were shown across each of the different therapeutic approaches. Some studies demonstrated a decrease in specific symptoms such as clinical depression for a majority of victims as measured by the BDI in three studies. Five studies showed a decrease in anxiety or other trauma-related symptoms. Other studies found significant improvements on symptoms specifically related to the type of intervention being provided, such as reduction in distorted thoughts in the CBT study, reduction in degree of "unfinished business," in an experiential study and solution of past issues in interpersonal/psychodynamic studies.

Childhood sexual abuse & Mental Health as constructed phenomena.

An important overlap exists linking both the epidemiology and outcomes of childhood sexual abuse and the construction of knowledge about mental health difficulties more generally (including our present systems of diagnostic classification such as the Diagnostic and Statistical Manual).

As an example, Shaw & Proctor (2005) outline the power relations that run through the diagnoses of personality disorders; particularly that of Borderline Personality Disorder. They highlight that around three quarters of those diagnosed with BPD are women, and that around 70-88% of those women are likely to have been sexually abused as children. Alongside this, Noll (2005) underlines that women who have been abused are often more likely to come into contact with abusers. This can be explained at a psychological level, but such explanations do not question or explore why there is such a degree of abuse in our society in the first place.

Shaw & Proctor (2005) argue for a more morally, socially and politically contextualised understanding of mental health disorders. They state that the psychiatric establishment often unwittingly serves to pathologise womens' oppression. For example, in the case of BPD it is left to a Psychiatrist to decide the appropriateness of a woman's emotional responses and interpersonal relationships. This medicalisation of conceivably understandable responses to sexual violence serves to protect society from owning up to its attitude to sex, violence and power (Shaw & Proctor, 2005). This kind of societal dissociation from the problem, by locating it solely within the individuals who suffer represents a closure of open, reflective and critical thinking.

A further example of the construction of knowledge concerning concepts of childhood sexual abuse relates to process research. Bolen (2002) argues that perhaps more than in other psychological fields, the evidence base and debates around childhood sexual abuse have emerged within a highly charged political and social context. As such, early theories of sexual abuse were susceptible to biases that reflected the larger socio-cultural context. Bolen (2002) underlines the notion that attachment theory can potentially add an important dimension to the conceptualization of child sexual abuse and its dynamics. However, it is also suggested that attachment theory may remain at risk for becoming a vehicle for transmitting political and ideological agendas obscuring for example political or economic influences on family life.

Societal issues such as gender and power greatly influence our understanding of and therefore the recovery of individuals from childhood sexual abuse. For example in western societies males are often raised to shoulder responsibility for what happens to them. In the context of childhood sexual abuse many victims may need help in understanding that the abuse was not their fault. This may require psychological as well as broader social and political interventions. Only then can they begin to accept that they were not responsible for the abuse (Banyard, 2004).

Conclusion

This review has highlighted that childhood sexual abuse remains a considerable problem both across the United Kingdom and internationally, in and of its own right.

Additionally, substantial evidence has accrued over the last twenty years underlining the dramatic and deleterious effects childhood sexual abuse often has on the mental health of those that experienced and suffered it. It may be that the wide ranges reported within epidemiological studies hint at undetected true prevalence and incidence rates which may be of relevance to clinical psychologists working in the community.

Childhood sexual abuse must be addressed at all ages, both psychologically, socially and politically. This is relevant both to victims and perpetrators. Psychotherapeutic approaches from different orientations have been found to be effective in reducing distress and psychopathological symptoms but care may be required to ensure that these promising results continue at long-term follow-up. This may be particularly the case given that a large proportion of sexually abused individuals are at risk of developing Axis II disorders.

Freyd et.al. (2005) conclude that research on childhood sexual abuse is at present scattered across numerous disciplines, which leads to a dispersal and poor dissemination of knowledge. As outlined above such knowledge can often contain implicit value judgments concerning children, men, women and families as well as the medico-scientific establishment. Further work should consider more closely the mediating processes by which poor psychological outcomes emerge as well as processes in recovery from those outcomes.

References

Ackard, D. & Neumark-Sztainer, D. (2003). Multiple sexual victimizations among adolescent boys and girls: Prevalence and associations with eating behaviors and psychological health. *Journal of Child Sexual Abuse, 12,1, 2003, 17-37.*

Alexander, P.C. (1992) The Application of Attachment Theory to the Study of Sexual Abuse. *Journal of Consulting and Clinical Psychology. 60, 2, 185-95.*

Anderson, M.C., Ochsner, K.N., Kuhl, B., Cooper, J., Robertson, E., Gabrieli, S.W., Glover, G.H., Gabrieli, J.D.E. (2004) Neural Systems Underlying The Suppression of Unwanted Memories. *Science, 303, 232.*

Bagley, C. (1991). The Prevalence And Mental Health Sequels Of Child Sexual Abuse In A Community Survey Of Women Aged 18 To 27. *Canadian Journal of Community Mental Health, 10, 103-116.*

Bagley, C., Wood, M., & Young, L. (1994). Victim To Abuser: Mental Health And Behavioral Sequels Of Child Sexual Abuse In A Community Survey Of Young Adult Males. *Child Abuse and Neglect, 18, 683-697.*

Baker, A. W. & Duncan, S. P. (1985). Child Sexual Abuse: A Study of Prevalence In Great Britain. *Child Abuse and Neglect, 9, 457-467.*

Banyard, V.L., Williams, L.M., Siegel, J.A., (2004) Childhood Sexual Abuse: A Gender Perspective on Context and Consequences. *Child Maltreatment, 9, 3, 223-238.*

Beitchman JH, Zucker K.J., Hood J.E., Dacosta, G.A., Akman D: (1991) A Review of the Short-Term Effects Of Child Sexual Abuse. *Child Abuse and Neglect, 15, 537-556*

Bentovim A. (2002). Preventing sexually abused young people from becoming abusers, and treating the victimization experiences of young people who of fend sexually. *Child Abuse and Neglect. 26, 6-7, 661-78.*

Bolen, R. (2002) Child Sexual Abuse And Attachment Theory: Are We Rushing Headlong Into Another Controversy? *Journal of Child Sex Abuse, 11, ,1, 95-124.*

Borch-Jacobsen, M. (1996) "Neurotica: Freud and the Seduction Theory", *October 76* October Magazine Ltd. and MIT, 15-43.

Brown J, Cohen P, Johnson JG, (1999). Childhood Abuse And Neglect: Specificity of Effects On Adolescent And Young Adult Depression And Suicidality. *Journal of American Academy Of Child & Adolescent Psychiatry. 38, 1490-1496.*

Bruckner, D. F. & Johnson, P. E. (1987). Treatment For Adult Male Victims of Childhood sexual abuse. *Social Casework, 68, 81-87.*

Carter, D., & Prentky, R. (1990). Overview of the program at the Massachusetts treatment centre. In D. Weisstaub (ED). *Law and mental health: International perspectives,* 9.104-119. New York: Pergamon Press.

Cawson, P., Wattam, C., Brooker, S. And Kelly, G. (2000) *Child Maltreatment In The United Kingdom: A Study Of The Prevalence Of Child Abuse And Neglect.* London: NSPCC.

Cioffi, F. (1974). 'Was Freud a Liar?', *The Listener*, 91: 172-4; reprinted (1975) *Journal of Orthomolecular Psychiatry, 5: 275-80.*

Chaffin, M.|, Silovsky, J.F.|& Vaughn, C.| (2005) Temporal Concordance Of Anxiety Disorders And Child Sexual Abuse: Implications For Direct Versus Artifactual Effects Of *Sexual. Abuse Journal Of Clinical Child & Adolescent Psychology, 34, 2, 210-222*

De Bellis M, Chrousos GP, Dorn LD, Et Al. (1994) Hypothalamic-Pituitary-Adrenal Axis Dysregulation In Sexually Abused Girls. *Journal of Clnical Endocrinology And Metabolis, 78, 249.*

Department for Education and Skills (2006) *Statistics of education: referrals, assessments and children and young people on child protection registers: year ending 31 March 2005.* [London]: The Stationery Office. Retrieved 10th Oct. 2006. **www.dfes.gov.uk/rsgateway/DB/VOL/v000632/index.shtml**

DeVoe, E.R. & Faller, K.C. (2002). Questioning strategies in interviews with children who may have been sexually abused. *Child Welfare. 81, 1, 5-31.*

Doyle, C. (1994) *Child Sexual Abuse; A Guide for Health Professionals*. Chapman & Hall, London.

Fergusson, D.M., Horwood L.J., Lynskey, M.T. (1996) Childhood sexual abuse And Psychiatric Disorder In Young Adulthood: II. Psychiatric Outcomes Of Childhood sexual abuse. *Journal of American Academy of Child Adolescent Psychiatry, 34, 1365-1374*.

Fergusson, D.M., Mullen, P.E. (1999) *Childhood Sexual Abuse: An Evidence Based Perspective. Developmental Clinical Psychology and Psychiatry*. SAGE Publications, London.

Finkelhor, D. (1986) *A Sourcebook on Sexual Abuse.* Beverly Hills, CA: Sage Publications.

Finkelhor, D., Hotaling, G., Lewis, I. A., Smith, C. (1990). Sexual abuse in a national survey of adult men and women: prevalence, characteristics, and risk factors. *Child Abuse and Neglect, 14, 19-28.*

Finkelhor, D. (1994) The International Epidemiology Of Child Sexual Abuse. *Child Abuse And Neglect, 18, 5, 409-417.*

Foote, B., Smolin, Y., Kaplan, M., Legatt, M.E., And Lipschitz, D. (2006) Prevalence Of Dissociative Disorders In Psychiatric Outpatients. *American Journal Of Psychiatry 163, 623-629.*

Freud, S. (1953-74) *The Standard Edition of the Complete Psychological Works of Sigmund Freud,* ed. and trans. by J. Strachey et al. London: Hogarth Press and the Institute of Psycho-Analysis.

Freyd, J.J., Putnam, F.W., Lyon, T.D., Becker-Blease, K.A., Cheit, R.E., Siegel, N.B., Pezdek, K. (2005) Policy Forum: The Science Of Child Sexual Abuse, *Science, 308, 5721, 501*

Furniss, T. (1991) *The Multi-Professional Handbook of Child Sexual Abuse. Integrated Management, Therapy and Legal Intervention.* Routledge, London.

Glaser, D., Frosh, S., (1993). *Child Sexual Abuse, Practical Social Work.* 2nd Edition. Macmillan Press, London.

Heger, A., Ticson, L., Velasquez, O., & Bernier, R. (2002). Children referred for possible sexual abuse: Medical findings in 2384 children. Child Abuse & Neglect. 26(6-7): 645-59.

Hepburn, J. M. (1994). The Implications Of Contemporary Feminist Theories Of Development For The Treatment Of Male Victims Of Sexual Abuse. *Journal 0f Child Sexual Abuse, 3, 1-18.*

Holmes, G.R., Offen, L., Waller, G. (1997). See No Evil, Hear No Evil, Speak No Evil: Why Do Relatively Few Male Victims Of Childhood sexual abuse Receive Help For Abuse-Related Issues In Adulthood? *Clinical Psychology Review, 17, 69-88.*

Holmes, W.C., & Slap, G.B. (1998). Sexual abuse of boys. *JAMA 2, 280(21), 1855-1862.*

Home Office (2006) Official Website:

http://www.homeoffice.gov.uk/documents/children-safer-fr-sex-crime?view=binary

Janssen, I., Krabbendam, L., Bak, M., Hanssen, M., Vollebergh, W., De Graaf, R., Van Os, J. (2004) Childhood Abuse as a Risk Factor for Psychosis. *Acta Psychiatrica Scandinavica. 109, 38.*

Katerndahl, D., Burge, S., Kellogg, N., (2005) Predictors Of Development Of Adult Psychopathology In Female Victims Of Childhood sexual abuse. *The Journal Of Nervous & Mental Diseases, 193, 4, 258-264.*

Kisiel, C. L. And Lyons, J. S. (2001) "Dissociation As A Mediator Of Psychopathology Among Sexually Abused Children And Adolescents" *American Journal Of Psychiatry 158, 1034-1039.*

Lampe A. (2002) The Prevalence Of Childhood sexual abuse, Physical Abuse And Emotional Neglect In Europe. *Z Psychosom Med Psychother, 48, 4, 370-80.*

Laporte, L., Guttman, (1996) Traumatic Childhood Experiences As Risk Factors For Borderline And Other Personality Disorders. *Journal Of Personality Disorders, 10, 3, 247-259*

Larkin, W., Morrison, A.T. (2006) (Eds) *Trauma And Psychosis.* John Wiley & Sons.

Lisak, D. (1994). The Psychological Impact Of Sexual Abuse: Content Analysis Of Interviews With Male Survivors. *Journal of Traumatic Stress, 7, 525-548.*

Lisak, D., Hopper, J., & Song, P. (1996). Factors In The Cycle of Violence: Gender Rigidity And Emotional Constriction. *Journal of Traumatic Stress, 9, 721-743.*

Lisak, D. & Luster, L. (1994). Educational, Occupational, And Relationship Histories Of Men Who Were Sexually And/Or Physically Abused As Children. *Journal of Traumatic Stress, 7, 507-523.*

Local Government Data Unit - Wales (2006) *Personal Social Services (PSS) statistics: Children on the Child Protection Register (SSDA 908.2).* Cardiff: Local Government Data Unit – Wales Retreived 10th October 2006.

www.lgdu-wales.gov.uk/eng/Data.asp?cat=167

Macmillan, H.L, Fleming, J.E., Streiner, D.L, Lin, E., Boyle,M.H., Jamieson, E., Duku, E.K., Walsh, C.A., Wong, M.Y.Y., Beardslee, W. R. (2001) Childhood Abuse And Lifetime Psychopathology, *American Journal Of Psychiatry 158, 1878-1883.*

Masson, J. M. (1984) *The Assault on Truth: Freud's Suppression of the Seduction Theory.* New York: Farrar, Straus and Giroux; new edn (1985) Harmondsworth, Penguin Books.

Molnar, B.E.,. Buka, S.L., Kessler, R.C. (2001) Child Sexual Abuse and Subsequent Psychopathology: Results From The National Comorbidity Survey. *American Journal of Public Health* 91, 753-762.

Morrison A.P., Frame, L., Larkin, W. (2003) Relationships Between Trauma And Psychosis. *British Journal of Clinical Psychology, 42, 331–353*

Noll, J.G. (2005) Does Childhood Sexual Abuse Set In Motion A Cycle of Violence Against Women? What We Know And What We Need To Learn; *Journal of Interpersonal Violenc, 20, 4, 455-462*

Northern Ireland, Dept. of Health, Social Services and Public Safety (2006) *Community statistics*: Belfast: Northern Ireland, DHSSPS. Retrieved 10th October 2006. **www.dhsspsni.gov.uk/master_community_statistics_(2004-05).pdf**

Peleikis, D.E., Mykletun, A. & Dahl, A.A. (2005) Current Mental Health In Women With Childhood sexual abuse Who Had Outpatient Psychotherapy *European Psychiatry 20, 3 , 260-267*

Piccinelli, M., Wilkinson, G. (2000). Gender Differences in Depression; Critical Review. *The British Journal of Psychiatry, 177, 486-492.*

Price, J.L., Hilsenroth, M.J., Petretic-Jackson, P.A., Bonge, D. (2001) A Review Of Individual Psychotherapy Outcomes For Adult Survivors Of Childhood sexual abuse. *Clinical Psychology Review. 21, 7, 1095-1121*

Polusny, M., & Follette, V. (1995). Long-term correlates of child sexual abuse. Theory and review of the empirical literature. *Applied and Preventive Psychology, 4, 143-166.*

Putnam, F.W. (2003). Ten-Year Research Update Review: Child Sexual. Abuse. *Journal Of . American. Academy of Child & Adolescent. Psychiatry. 42, 3, 269-278.*

Read, J., Agar, K., Argyle, N., Aderhold, V. (2003) Sexual And Physical Abuse In Childhood And Adulthood As Predictors of Hallucinations, Delusions And Thought Disorder. *Psychology & Psychotherapy: Theory, Research And Practice, 76,* 11-22

Romans, S.E., Martin, J.L., Morris, E., Herbison, P. (1999) Psychological Defense Styles In Women Who Report Childhood sexual abuse: A Controlled Community Study, *American Journal of Psychiatry 156, 1080-1085.*

Schore, A. N. (2003) *Affect Dysregulation and Disorders of the Self.* New York, Norton & Company.

Scottish Executive (2006) *Child Protection Statistics 2005/06.* Edinburgh: Scottish Executive National Statistics.

Shaw, C., Proctor, G. (2005) Women At The Margins: A Critique Of The Diagnosis Of Borderline Personality Disorder. *Feminism & Psychology, 15, 4, 483-490.*

Siegel, J. M., Sorenson, S. B., Golding, J. M., Burman, M. A, & Stein, J.A. (1987). The Prevalence of Childhood Sexual Assault: The Los Angeles Epidemiology Catchment Area Project. *American Journal of Epidemiology, 126, 1141-1153.*

Spataro, J., Mullen, P. E., Burgess, P. M., *Et Al* (2004) Impact Of Child Sexual Abuse On Mental Health: Prospective Study In Males And Females. *British Journal of Psychiatry, 184, 416 -421.*

Widom, C. S., And Ames, M. A., (1994) Criminal Consequences of Child Sexual Victimization. *Child Abuse and Neglect, 18, 303-318*

Appendix 1:

Literature Search Audit

The following electronic searches were undertaken via Psych-Info. Due to the overwhelming number of relevant papers the search was limited to the years 2000- 2006 for English Language Journals. From these references other key references prior to 2000 were obtained and sited in the review because of their importance in the literature. Key search words are in brackets below.

i. (adult psychopathology)and(childhood)and(sexual abuse) 2006 = 2 papers

ii. (adult psychopathology)and(childhood)and(sexual abuse)2000-2005= 11 papers

iii. (Child)and (Sexual Abuse)and (effects) 2006= 40 papers

iv. (Child)and (Sexual Abuse)and (effects) 2000-2005 =484 papers

v. (mental health)and(sexual abuse)and(childhood) 2006= 38 papers

vi. (mental health)and(sexual abuse)and(childhood) 2000-2005 = 258 papers

vii. (psychosis)and(sexual abuse)and(childhood 2006 = 2 papers

viii. (psychosis)and(sexual abuse)and(childhood 2000-2005 = :7 papers

Appendix 2:
Child Protection Figures for England, Wales, Scotland & Northern Ireland.

Registrations to child protection registers during the years ending 31st March, by category of abuse

Category of abuse	2001	2002	2003	2004	2005
Neglect	12,400	10,800	11,700	12,600	13,200
Physical abuse	8,000	5,300	5,700	5,700	5,500
Sexual abuse	4,300	2,800	3,000	2,800	2,700
Emotional abuse	4,600	4,700	5,400	5,600	5,700
Categories not recommended by 'Working Together'	420	-	-	-	-
No category available (transfer pending conferencing)	180	-	-	-	-
Mixed / not recommended by 'Working Together'	-	4,100	4,400	4,300	3,700
Total of all abuse categories	29,900	27,700	30,200	31,000	30,800

Figures taken from tables 3c and 5c in:
Department for Education and Skills (2006) Statistics of education: referrals, assessments and children and young people on child protection registers: year ending 31 March 2005.

Child protection register statistics
Wales 2002 - 2006
Children and young persons on the child protection register at 31 March, by category of abuse

Category of abuse	2002	2003	2004	2005	2006
Neglect, physical abuse and sexual abuse	15	9	15	16	9
Neglect and physical abuse	114	154	128	122	138
Neglect and sexual abuse	29	59	39	64	38
Physical abuse and sexual abuse	16	34	42	23	21
Neglect (only)	789	935	932	973	1,057
Physical abuse (only)	409	440	387	424	343

Sexual abuse (only)	192	178	186	177	147
Emotional abuse (only)	407	425	428	470	410
Total of all abuse categories	1,971	2,234	2,157	2,269	2,163

Figures taken from:
Local Government Data Unit - Wales (2006) Personal Social Services (PSS) statistics: Children on the Child Protection Register (SSDA 908.2). Cardiff: Local Government Data Unit - Wales.

Children registered in Scotland following a case conference year ending 31 March, by category of abuse/risk identified by conference

Category of abuse/risk	2002	2003	2004	2005	2006
Physical injury	644	766	741	628	779
Sexual abuse	249	310	234	226	301
Emotional abuse	264	438	434	376	442
Physical neglect	809	969	1,015	1,035	1,243
Failure to thrive	13	33	16	11	6
Unknown	-	-	-	18	20
Total	1,979	2,517	2,440	2,294	2,791

Figures taken from tables 4 and 7 in:
Scottish Executive (2006) Child Protection Statistics 2005/06. Edinburgh: Scottish Executive National Statistics. ISBN: 0755962680
Northern Ireland 2001 – 2005 Number of children on the Child Protection Register at 31st March by category of abuse

Category of abuse	2001	2002	2003	2004	2005
Neglect, physical and sexual abuse	13	11	9	11	15
Neglect and physical abuse	87	104	119	122	153
Neglect and sexual abuse	28	29	23	30	49
Physical and sexual abuse	35	32	28	31	30
Neglect (only)	526	625	651	509	554
Physical abuse (only)	340	359	376	330	316
Sexual abuse (only)	189	159	178	164	234
Emotional abuse (only)	196	212	224	220	242
All categories of abuse	1,414	1,531	1,608	1,417	1,593

2005 figures taken from table 2.6 in:
Northern Ireland, Dept. of Health, Social Services and Public Safety (2006) Community statistics: 1 April 2004 - 31 March 2005. Belfast: Northern Ireland, DHSSPS.

WOMEN'S EXPERIENCES OF CHILDHOOD SEXUAL ABUSE AND PSYCHOSIS IN ADULTHOOD

Nathan David O'Neill

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"...the past should be altered by the present as much as the present is directed by the past."

T.S. Eliot "Tradition and the Individual Talent." From *The Sacred Wood: Essays on Poetry and Criticism.*

Abstract.

Objective: To date there have been few if any qualitative studies of adults who have experienced childhood sexual abuse (CSA) followed by psychotic experiences later in life. This study aimed to explore how a sample of four women make sense of their childhood experiences of sexual abuse and their psychotic experiences later in life.

Methodology: Data was gathered through semi-structured interviews with four women. The data were analysed using Interpretative Phenomenological Analysis (IPA) in order to develop a detailed understanding of the women's search for meaning in their own lives.

Results: Four major themes emerged from the analysis of the women's accounts: *'Interpersonal difficulties,' 'Striving to Get Better'* and *'A Relationship with Shame' and 'Links Between CSA, Mental health & Psychosis'.* These are explored in detail.

Conclusions: The women's accounts highlight the ongoing difficulty of living with psychosis and CSA, in particular, the role of psychosis in exacerbating isolation, shame and negative self perceptions. Attention is also drawn to the development of competence for therapists in this area of work.

Clinical Implications: Supporting and validating existing healthy coping strategies as well as exploration of the interaction of psychosis and CSA through psychological mechanisms of shame as well as family / society discourses. Therapist/ researcher self-awareness is crucial in supporting clients with such traumatic histories.

CHAPTER 1: INTRODUCTION

1.1. HOW I CAME TO THIS STUDY

I'm a thirty two year, old white, secular, single Scottish man. I've been a paper boy, a potato picker, a bicycle mechanic, a postman, a factory worker. I've worked in a bar/ restaurant and in a call centre and I've been to university. I worked as a student mentor, a volunteer advocate, a residential support worker, an assistant psychologist and a researcher. I'm now a clinical psychology trainee. Through my twenties I have sometimes struggled with my own thoughts and emotions e.g. comparison with friends, money, striving for achievements and avoiding personal suffering. These personal and work experiences contextualise my theoretical understandings, and have shaped my opinions around mental health issues.

My work involving people with mental health problems has highlighted the need for an awareness of everyday factors such as jobs, money, housing, social supports and attachments as well as symptoms. I have found that thinking with people about difficult experiences is often avoided, interrupted or skewed; either through personal, interpersonal or wider systemic and institutional factors. How can we notice these interruptions and reconnect with our thinking?

These experiences and questions are central to my current position in relation to research. Throughout my undergraduate and graduate education I have sought to make sense of the various strengths and limitations of quantitative and qualitative research paradigms in psychology and sociology. My concern has been to avoid positivistic assumptions often found in quantitative research, but to find a qualitative methodology that can provide robust knowledge that would be of practical and immediate use to clinicians yet explicitly couched in a philosophical and historical context. In this sense Smith's seminal 1996 paper on IPA, drawing together discursive and realist traditions fitted closely to my current research aspirations. In particular, I am interested in the production of research involving the researcher and facilitating a reflective clinical practice. Another component of my interest has been following the rise of psychological research and clinical expertise in relation to psychosis. I have been strongly influenced by the work of Mary Boyle, Richard Bentall, John Read, Warren Larkin, Anthony Morrison, Philippa Garety and others who have in my view increased our psychological understanding and confidence in working with psychotic experiences in the face of a hitherto strongly medicalised view of psychosis. This research project has thus provided me with an opportunity to extend my clinical and personal awareness of substantive and discursive issues regarding sexual abuse and psychosis, as well as strengthening the links between my own reflective stance as a practicing clinician and researcher.

This project is about women's experiences of childhood sexual abuse and psychosis. It is a qualitative study aiming to give a rich description of the experiences of those who have suffered and coped, often despite medication and psychotherapy. The purpose is not to look for causal relations or to categorise illnesses or people. Nor is the purpose to develop a new theory, as in a grounded theory approach, or to make assertions about all psychoses and abuse perpetrated against children. Here, using a qualitative research paradigm, the purpose is to explore and attempt plausible understanding and theoretical integration of the experiences of the participants.

Ultimately, I hope this will serve a pragmatic purpose in adding to our growing understanding of ways of thinking about and talking with individuals who have endured such experiences. This lends weight to an approach to mental distress which tends not to focus solely on symptoms or classification systems, but emphasises the person as a whole, within a social context and with a personal history. As such, this project seems congruent in approach with my development as a person, and my identity and interests as a clinical psychology trainee.

1.2. INTRODUCTION TO THE STUDY

This study focuses on women's experiences of childhood sexual abuse and psychotic phenomena such as delusions and hallucinations later in life. In this introductory chapter I will initially sketch the growing body of quantitative evidence that suggests childhood sexual abuse is a relevant and significant risk factor in the development of psychosis in adulthood. This underlines the appropriateness of bringing together two large and separate fields of enquiry: Childhood Sexual Abuse (henceforth 'CSA' to save word space) and Psychosis within this research project.

I will go on to examine recent qualitative studies in the fields of psychosis and of CSA – in particular studies using Interpretative Phenomenological Analysis (IPA). This serves as a backdrop to using IPA for this study and aims to move the reader from the initial quantitative considerations to the more qualitative consideration of the 'lived experiences' of people traversing either sexual abuse or psychosis experiences.

This study draws on qualitative research that has attempted to explore either the realities of living with the effects of CSA or of psychosis in adulthood. In closing this chapter, attention will be drawn to the lack of research that attempts to bring these two areas together. The current lack of unified research in this area underlines the appropriateness of using a qualitative methodology in this study, to begin an important task of mapping out what it might be like to live through both of these traumatic experiences. Finally, this chapter will outline the specific aims of this research project.

1.3. CHILDHOOD SEXUAL ABUSE AND PSYCHOSIS IN ADULTHOOD (QUANTITATIVE EVIDENCE FOR A MEANINGFUL LINK)

There is an extensive body of literature indicating that childhood trauma, and specifically childhood sexual abuse, are significant risk factors for developing a range of psychopathologies in adulthood including increased rates of: anxiety, depression, antisocial behaviour, substance misuse, suicide and self harm, sexual dysfunction and post traumatic stress (see Fergusson & Mullen, 1999; O'Neill, 2006 for comprehensive reviews). Busfield (1996) highlighted four main factors in increasing the likelihood of negative mental health outcomes following CSA. They are the duration of abuse, the use of force or coercion, abuse by father or stepfather (incest) and the involvement of penetration such as intercourse or oral genital contact. In their review of the research on adult outcomes of childhood sexual abuse (Bagley & Thurston, 1996), several interesting results were reported. In particular, a family climate characterized by secrecy, communication and attachment problems, other forms of abuse (e.g., emotional, physical), and feelings of shame and guilt on the part of the victim was found to be associated with greater psychological impairment among victims. In addition, the family's reaction to the disclosure of sexual abuse was found to be critical in terms of the psychological sequelae of the abused individual. Bagley & Thurston (1996) also found that a loving, accepting, open family can minimize harm resulting from abuse, for example, by not blaming a victim following revelation of CSA. Evidence specifically examining the possibility of links between CSA and the later development of psychosis is somewhat more controversial.

Spataro et al. (2004) found no increased likelihood of developing a psychotic disorder in adulthood following CSA. Their study of over two thousand psychiatric patients pointed to increased psychopathology in general but not to psychosis in particular. However, their large sample had been drawn from adults up to the age of twenty years who had been removed from their abusive environments. Spataro et al. (2004) had therefore examined a population who were younger than the average age of onset of psychotic disorders and also crucially had received relatively early support and acknowledgement of their abuse by services (Read et al., 2006).

In contrast to Spataro et al.'s (2004) findings, over the past ten to fifteen years an increasing amount of quantitative evidence has pointed to CSA as a significant risk factor in the development of psychosis in adulthood (Larkin & Morrison, 2006). Bebbington et al. (2004) used a sample size of over eight thousand from the second British national survey of Psychiatric Morbidity in their analysis of the relationship between psychotic disorders and a number of traumatic childhood experiences of a victimizing nature. They found the largest odds ratio in relation to psychotic case-ness was for childhood sexual abuse. Similarly, Jaansen et al. (2004) found that individuals who had suffered severe CSA were almost fifty times more likely than individuals in the general population to later experience 'pathology' level psychosis. Read et al. (2005) explored the research literature describing raised levels of CSA within psychotic populations. Read et al. (2005) concluded that the literature indicates childhood trauma may in some cases, through increased stress levels, be causally related to the development of psychotic symptomatology later in life, perhaps by contributing to a stress vulnerability model.

Two key issues are worth considering in order to adequately contextualise these divergent findings. Firstly, much of the research regarding prevalence and impact of CSA is subject to methodological caveat, regarding different research methods, definitions of CSA and specific research questions (O'Neill 2006). Secondly, the degree to which certain members of society may feel able to disclose CSA (for example males versus females) in the first place is likely to be mediated by multiple factors such as shame, embarrassment and fear (Wurr et al. 1996). From the point of view of psychiatric patients who are interacting with a relatively powerful medico-legal infrastructure the disclosure of abuse may vary significantly according to personal factors as well as broader power dynamics. In relation to this last point, Jacobson and Herald (1990) found that forty four per cent of psychiatric inpatients who had experienced serious abuse had not disclosed it to anyone, including prior therapists. This was despite the fact that, when asked, these patients often reported that the abuse experiences continued to affect their current psychological functioning.

There is therefore some disagreement within the current quantitative literature regarding the precise extent to which experiencing CSA may be considered a causal factor in the development of psychosis in adulthood. Regardless of this debate however, there are numerous studies (Larkin & Morrison, 2006) as well as anecdotal clinical knowledge pointing to a large number of individuals who have suffered or are suffering from psychotic symptoms and who describe having had sexually abusive experiences in childhood. Outside of the causality debate qualitative researchers have so far asked: what is it like to live through either of these traumatic experiences?

1.4. QUALITATIVE STUDIES IN PSYCHOSIS

To date qualitative studies (including IPA) have mainly centred on considerations of psychotic content, the role and construction of self, approaches and themes in recovering and religiosity (Beese & Stratton 2004; Boevink, 2006; Campbell & Morrison 2007; Chapman, 2006; Forchuck et al. 2003; Green et al. 2006; Hirchfield, 2005; Humberston, 2002, Lysaker & Lysaker, 2002; Macdonald, 2005: McCabe, 2002; Knight, 2003: Rhodes & Jakes, 2000, 2004: Sell et al. 2004: Thornhill & May 2004: Drinna & Lavender, 2006).

1.4.1 Psychotic content and meaning

In a qualitative study examining interactions between mental health professionals and patients with psychosis, patients repeatedly attempted to talk about the content of their psychotic symptoms, which was a source of noticeable interactional tension and difficulty for professionals. The authors concluded that addressing patients' concerns about their illness may lead to more satisfactory consultation outcomes and improve patient engagement with health services (McCabe et al., 2002). Rhodes and Jakes (2000) examined the way in which delusional content could be related to the life problems and goals of participants. Using IPA they found six main themes: social connection; competence; experiential base (i.e. states of mind and body); material base (e.g. housing); direction; and evaluation (i.e. how a person evaluates himself or believes others evaluate him). Rhodes and Jakes (2000) concluded that delusions did appear to relate to fundamental ongoing concerns in a person's life. Rhodes and Jakes (2004) later examined the role played by metaphor and metonymy in accounts of psychosis as potential linking mechanisms between psychotic experiences and everyday life concerns. They suggested that the use of metaphor by participants acted to shape interpretations of experience. Rhodes & Jakes (2004) concluded that step by step examinations of delusion formation, incorporating an individual's developmental history might be an important avenue to further our understanding of psychosis.

1.4.2. The role and construction of self

Campbell and Morrison (2007) used IPA to look at the experiences of paranoia described by psychiatric patients and non-patients. They found that psychiatric patients spoke differently about their experiences of self and emotion, describing more separated selves and less control. The authors concluded that further research regarding the appraisals of self, psychosis and trauma events would be beneficial. Lysaker and Lysaker (2002) explored the 'dialogical' or narrative structure of self in relation to 'Schizophrenia' drawing on ideas from a long history of western intellectual thought including Mead, Vygotsky and Nietzche. Their literature review and theoretical paper suggested that 'Schizophrenia' represents a break-down in the ability of self positions to communicate with one another. Failure to access 'self-positions' may lead individuals to believe that contents of their selves have been destroyed. This may be reinforced by services conceptualizing recovery in terms of 'rebuilding', or refilling a person's 'self' , emphasizing a return to how they were prior to illness, while ignoring the impact, changes and growth that may have taken place as a result of the psychosis. They point to the need for therapists to create non hierarchical relationships that encourage clients into dialogue with therapists, others and with conflicting aspects of their own selves.

1.4.3. Approaches and themes in recovering

Knight et al. (2003) used IPA to focus on the experiences of participants in their recovery from psychosis. This included exploring the experiences participants described about stigma in relation to family, friends, society, police and mental health professionals. They also describe significantly lowered self-esteem, and how stigma had led to behavioural changes. Some participants continued to experience stigma related to diagnostic labels such as ‘schizophrenia’ despite alleviation of frank psychotic symptoms for several years. Knight et al. (2003) highlighted the fact that research into the experience of mental health must take account of the views of mental health service consumers, and that IPA is an effective tool for this aim. Sell et al. (2004) focused on issues around recovery from schizophrenia. Drawing on a number of qualitative studies they concluded that recovery in schizophrenia often revolved around the reclamation of an enduring sense of self; that is, a person coming to know themselves as an active social participant with felt senses of self esteem, self efficacy and separated from discourses of illness. They concluded therapists should move away from illness models and help clients construct personal spaces within communities to facilitate client self-definition (Sell et al, 2004). Similarly, Forchuck et al. (2003) examined participants’ descriptions of recovery from psychosis as a process that involved improvements in people’s thinking and feeling, accompanied by reconnections with their environment, family and wider networks. Participants described recovery as involving the entire self, bringing all components of physical, emotional, mental, and spiritual aspects of themselves into their experiences of life. Hirschfield et al. (2005) explored the experiences of young men who had been psychotic. They found themes of experience and expression of psychosis, personal and interpersonal changes and explanations. Their study highlighted the role of post psychotic depression, avoidant and integrative coping styles and the need for professionals to work with multiple explanations of causality in psychosis. Macdonald et al. (2005) emphasised how young people's concerns were similar regardless of having experienced psychosis or not. This included engaging in activities, and with valued and supportive others. However, young people who had experienced psychosis also had to navigate their own and others' reactions to their psychosis by withdrawing from prior perceived harmful lifestyles, social networks and activities and engaging with new alternatives if available; challenges that are not easy to surmount by oneself.

1.5. QUALITATIVE RESEARCH ON THE EFFECTS OF CSA

Recent qualitative research on the experiences of men and women who have been exposed to CSA has tended to focus on issues revolving around shame and stigma, mechanisms involved in resiliency, and treatment and recovery approaches (Bogar and Hulse-Kulacky, 2006: Finkelhor and Browne, 1985: Grossman et al., 2006: Herringshaw, 1997; Negrao et al., 2005: Perrot et al. 1998: Phillips and Daniluk, 2004: Rahm et al., 2006;).

1.5.1. Shame

Finkelhor and Browne (1985) suggested that internalized shame often follows from CSA by directly attacking or undermining the victim's sense of self. Survivors may then continue engaging in activities that entrench or reinforce their low self-esteem.

Negrao et al. (2005) explored the role of shame, humiliation and childhood sexual abuse. From coding verbal and non-verbal components of narrative interviews they found verbal humiliation to be significantly associated with nonverbal displays of shame. They also found that verbal humiliation and non-verbal shame were associated with increased levels of post traumatic stress. Rahm et al. (2006) explored how women verbally expressed unacknowledged overt and covert shame, when interviewed about their physical and mental health, relations and circumstances in relation to childhood sexual abuse. They found shame to be present and negatively influencing the lives of the informants as adults.

1.5.2. Resiliency

Perrott et al. (1998) found that in terms of cognitive coping strategies women who experienced CSA and who "deliberately suppressed" memories of the sexual abuse incidents were more likely to have low self-esteem. They also found that women who "reframed" their abusive pasts in a meaningful way were significantly less likely to receive psychiatric diagnoses (Perrot et al., 1998). Bogar and Hulse-Kulacky (2006) undertook a qualitative study examining the concept of resiliency among ten women who had been sexually abused as children. In their sample resiliency was found to comprise aspects of interpersonal skills and competencies, preserved self-esteem and positive or helpful experiences and frameworks such as spirituality. In addition, they described the idea that resilience is a process rather than a set of static factors or traits including coping strategies, refocusing, active healing, and achieving closure.

1.5.3. Recovering

Herringshaw (1997) described recovery in adult survivors of childhood sexual abuse as requiring an "existential truce" whereby individuals reintegrated their traumatic experiences into a new narrative of self. The authors concluded that subjects ultimately let go of their search for a meaning to their childhood trauma. In another phenomenological study, women's self-definition, self-acceptance, sense of visibility, connection to others, current worldview, and residual losses were implicated in the re-authored identities of women who had experienced CSA. Phillips and Daniluk (2004) emphasised a growth and change model of recovery for therapeutic interventions in CSA. Grossman et al. (2006) found that male survivors of CSA who developed psychological frameworks for understanding the abuser or the role of the self in the abuse, using sociocultural spiritual or philosophical explanation, were better able to recover from trauma. Their meaning making seemed to increase with exposure to specialized trauma therapy.

1. 6. STRENGTHS AND LIMITATIONS OF EXISTING LITERATURE

These quantitative and qualitative studies offer a pluralistic approach to both causal explanation and meaningful understanding of CSA and psychosis, a goal for mental health research outlined by Karl Jaspers almost a century ago (Ghaemi, 2004). In reference to the present study, qualitative research has brought us a long way in developing a more complete and nuanced understanding of the phenomenological experiences that characterise psychosis and CSA. This has also challenged modernistic assumptions about the empirical status of particular kinds of knowledge (Chalmers, 1990, 1999: Gillett, 1995: Harper, 2004: Harre & Gillett, 1994). In the realm of practising clinical psychologists, this has helped to acknowledge and close a frequently ignored separation between ‘scientist’ and ‘practitioner’. This has helped to give more weight to research participants’ subjective experiences within published work, as it is given in the clinic.

However, despite the considerable strengths of the above literature there remains a considerable paucity of qualitative studies specifically examining the lived experiences of people with both psychosis and CSA histories. Fergusson and Mullen (1999) describe a general process through which CSA has been previously researched with specific reference to adult psychopathology. They suggest that the research generally moves from initial clinical observations of high rates of CSA among a given disorder (in this case psychosis) towards more specific and robust research that examines linkages between CSA and mental health outcomes. This study might be considered to be a qualitative link in that wider research process uncovering and exploring processes within CSA and psychosis.

1.7 AIMS OF THIS STUDY

This study aims to explore the descriptions participants give of their experiences of being sexually abused as a child, and of having been psychotic during their adulthood. It is important to note that the aim is not to attempt further legitimization of quantitative studies that point to a link between CSA and psychosis. On the other hand, this study does aim to move beyond a descriptive analysis of the participants' experiences of CSA and psychosis. The use of IPA in this study aims to construct an account of participants' experiences through engaging with their testimony, wider literature and my own experiences as a clinical psychology trainee (Smith, 2003). It is hoped this will provide a good understanding of these women's experiences and provide information to help further develop psychological treatments for those with psychosis and / or a history of CSA.

1.7.1. Research questions

In order to achieve the stated aims of this study, the following overall research question was formulated:

How have women experienced sexual abuse in childhood and psychosis during adulthood?

This overall research question was broken down into three sub-questions:

A. How have women been affected by experiences of psychosis?

This first section included exploration of any mental health problems or long-term difficulties experienced by the participants and how they might have developed. This then moved onto questions regarding their experiences of diagnoses, of psychosis and psychotic episodes. This section was explored first due to its more recent (adulthood) occurrence. It also therefore served as precursor to sections B and C.

B. How have women been affected by experiences of childhood sexual abuse?

This second area initially explored participants' feelings about childhood in general. This then set the scene for enquiring about the effect or effects the sexual abuse may have had on them as children or young people. Finally, this section explored whether participants felt that effects of CSA had altered or evolved during their adulthood. It was important to also explore this area in relation to existing literature in the field. This and the previous section provided a detailed and meaningful framework to engage participants in the final crucial section C.

C. What, if any, links are made by participants or can be discerned in their accounts between childhood sexual abuse and psychotic experiences?

This main section explored whether clients might consciously make links between their experiences of CSA and their mental health problems (particularly the psychosis). This included a summing up question about how participants felt both sets of experiences had affected them as people. I also acknowledged that participants might talk in more implicit ways about their experiences being linked and interrogated the transcripts for any such implicit linkages. This section represented the key component of this research project and followed the preparatory discussions of psychosis and CSA.

(see Appendix D for interview schedule)

CHAPTER 2: METHODOLOGY

2.1. INTRODUCTION

This chapter will provide the rationale for choosing a qualitative method in addressing the research questions outlined at the end of Chapter 1. A description of the chosen method, Interpretative Phenomenological Analysis (IPA), will follow to both orient the reader and to explain the rationale for and use of this particular research method in this study. This chapter will also include some of the drawbacks encountered by researchers using this approach. Consideration will then be given to the broad setting of the research project to give detailed contextualisation. This chapter will then outline the design, methodology, data collection and analysis undertaken during this study. Finally, I will give personal reflections of my experiences in undertaking to interview participants about their experiences with childhood sexual abuse and psychosis in adulthood.

2.1.1. A Qualitative approach

Research that aims to explore the meanings that particular phenomena have for people, rather than test specific causal hypotheses, is particularly well served by a qualitative approach. This is because greater emphasis can be placed on gathering a rich description of a process or experience that may not be sufficiently captured by existing psychological research measures (Willig, 2001).

The aim of this study is to describe and explore in detail what it means for the participants to have experienced childhood sexual abuse and psychosis in adulthood. Additionally, the focus on exploration is highly pertinent to studying psychosis where, in the UK over the last 15 years, clinical psychology has begun to question the established psychiatric view that psychotic phenomena are essentially ‘meaningless’ in their content (Berrios, 1991) and therefore of no clinical or research value. As such, a qualitative approach can give voice to narratives that often go unheard within mainstream psychiatric services.

2.1.2. Interpretative Phenomenological Analysis (IPA)

IPA aims to understand as clearly as possible what a given participant or group of participants think or believe about a given topic through analysing texts (Smith & Osborn, 2003). In this respect it differs markedly from qualitative methods such as discourse analysis which consider texts as socially constructed gestures and makes no assumptions about putative links between textual discourse and proposed underlying cognitions (Willig, 2001). IPA draws on phemonenological and interpretative traditions within the social sciences (Smith, 1996).

Phenomenological

IPA assumes that texts represent, however loosely, something of the underlying thoughts, beliefs and experiences of participants (Smith 1996). In this respect, texts may be seen to emerge out of the ‘phenomena’ or ‘lived experience’ of persons and of their attempts to make sense of their own experiences. The use of semi-structured interview techniques is viewed as a highly effective way of eliciting from a participant a rich account of their experiences.

Interpretative

IPA posits that qualitative research should go beyond mere description of a participant's world (Smith, 1996). That is, there should be an interpretative element to help contextualise and make sense of an individual's experiences. In IPA the text serves as a medium through which the researcher can grapple to try to understand the subjectively lived experience of a participant. This 'double hermeneutic' (Smith, 2003) represents the researcher's interpretation of the participant's view of their experiences. Through engaging with the project the researcher attempts also to make explicit their own evolving personal, professional theoretical stance. In this way, the reader, although not necessarily in agreement with the researcher, should be able to follow clearly the decisions and conclusions of the research.

2.1.3. Reflecting on the use of IPA

Willig (2001) describes how reflecting on the chosen methodology should be a requirement in addressing its appropriateness or sensitivity to the original research question, the topic under consideration and the participants who will be interviewed. Making the assumptions of the chosen methodology more explicit addresses some of the concerns regarding social construction of knowledge and encourages a researcher and reader to consider their own assumptions about a piece of research and the kinds of conclusions that can be drawn from it.

IPA and knowledge

IPA acknowledges that it is impossible to obtain direct unmediated access to an individual's world (Smith, 1996). However, the aim is to gain as good an insight as possible into the person's experiences of the phenomena under investigation. It therefore assumes that someone's account, verbal or otherwise, can inform us of their thoughts and feelings which are assumed to capture someone's experience of phenomena. This is a realist stance in which an account of experience corresponds to actual existing phenomena. Additionally, the researcher's life world is not viewed as an impediment, but rather as necessary in enabling him or her to make sense of the participant's account by relating it to his/her own experience (Smith, 1996).

IPA's assumptions about the world

Having outlined IPA's realist ontology, there is a tension in that IPA is also interested in the subjectively experienced world, rather than the verification (per se) of an objective world (Smith, 1996). That is, whether an account is 'objectively' true or not is not a primary concern, as perhaps in more quantitative approaches. People can experience the same event in diverse ways or attribute meanings to events which then shape their experiences of those events. This may be defined as a relativist epistemology.

The goals of IPA

Smith and Osborn (2003) suggest that the goal of IPA is not necessarily to generalise from the sample to a given population, as in certain quantitative paradigms. Factors including the sample size, the homogeneity of a sample, sex of participants, purposive sampling technique, and their ability to narrate their accounts may all provide limitations to 'generalisability' in IPA. However, although the aim of IPA is not primarily to produce generalisable results per se, it does not follow that one cannot generalise, or utilise the knowledge raised by a set of findings, for example applying insights gained in working with one group of people to another group (Smith, 2003). Neither is the goal that of sampling to achieve 'saturation' of a concept or construct as in grounded theory. Rather, the goal is to build a rich picture of a specific phenomenon, using a case by case or idiographic approach.

Smith and Osborn (2003) state that optimal sample size depends on factors such as the degree of commitment to levels of analysis, the richness of individual accounts and the constraints under which one operates. Rough numbers of five or six participants are suggested, although they acknowledge that published IPA studies have involved fewer than this number (Smith & Osborn, 2003; de Visser & Smith, 2006). In line with this, the richness of accounts provided by participants in this study mitigates the relatively small sample size of four. Additionally, this study aims to approach these rich accounts at varying levels of analysis, further reducing the possible negative impact of sample size. Finally, the high degree of homogeneity in this sample also increases validity of the study.

2.2. DESIGN

2.2.1. Participants

The data were drawn from four audio-taped interviews with four participants. Sample size approached consistency with recent IPA papers on psychosis (Knight et al., 2003) and guidelines for conducting IPA studies (Smith 1999, Smith & Osborn, 2003).

2.2.2. Recruitment strategy

All participants were recruited through the Clinical Psychology Outpatients Department of a hospital in London. All four of the participants had been seen or were beginning Cognitive Behavioural therapy as outpatients with the psychology department. One participant had received individual and group psychotherapy (also at the hospital). The participants were contacted by myself after John Rhodes (field supervisor) had met with the individuals regarding ongoing psychotherapy and asking if they would be interested in taking part in the research. If they said yes and were interested in the study, John asked if he could pass their contact details to me. All participants who had said yes to John were then phoned prior to interview by myself to develop participant-researcher rapport and to gauge their appropriateness both in terms of the inclusion and exclusion criteria. Additionally this was important in checking their readiness and motivation to participate in the study. At this point the informal nature of the interview was stressed to participants. It was also explained that the intention was not to ask participants to disclose anything they did not wish to, including details of any sexual abuse they had experienced. If participants were still interested to in undertaking the interview, a date and time was arranged to meet either at the hospital or, in one case, at a local community mental health team building. It was felt important to interview participants in environments familiar to them to ease rapport building and reduce potential anxiety for participants prior to interview.

2.2.3. Inclusion and exclusion criteria

Following Bentall, Jackson and Pilgrim (1988) and Bentall (2004), I included participants with psychosis from any psychotic syndrome classification, as the status of ‘shizophrenia’, ‘schizoaffective Disorder’ as distinct and unproblematic categories of pathology is contested (Boyle, 2002). Individuals were included if they had received a diagnosis of psychosis or schizophrenic type illness at any point during adulthood as ascertained by participants’ testimony as well as by medical notes.

The second criterion for inclusion was the presence of childhood sexual abuse defined as moderate to severe on Bernstein and Fink’s (1998) Child Trauma Questionnaire (CTQ) (See Appendix H). The CTQ is a 28 item questionnaire giving an indication of the presence and severity of childhood abuse, including sexual abuse. It was used to give an indication of the presence and severity of childhood sexual abuse in someone’s life. Fink et al. (1995) point to a strong correlation (0.58) between reported CSA in a structured trauma interview and the CTQ. Similarly, Bernstein et al. (1997) found a correlation of 0.75 between CSA rated by independent therapists and using the CTQ.

As is clear from the literature (Fergusson & Mullen, 1999) sexual abuse is unlikely to have occurred without also concomitant emotional and physical abuse. However, for this study it was important to interview participants who regarded the sexual abuse as the most significant and problematic aspect of their childhood so as to increase the likelihood of a homogenous sample. If sexual abuse occurred with other forms of abuse or neglect as identified on the CTQ, individuals were included if the sexual abuse component was significantly greater than the other component/s. Additionally this was cross-referenced with the individual testimonies of the participants at interview. That is, had a participant described non sexual abuse as being of much greater emotional or psychological impact than the sexual abuse, their data would have been excluded. However, in practice this issue did not arise. Participants who were acutely psychotic or unwell were excluded from this study. Current mental health status and appropriateness for inclusion in this study was also ascertained in conjunction with participants' care-coordinators where participants wished to do so.

For the purposes of this study 'childhood' will be defined as being below sixteen years of age at the time of sexual contact (Home Office, 2006). Although clearly abusive, non-consenting sex above sixteen years of age (as in the original CTQ validity trials) was not considered to fall into the category of '*childhood* sexual abuse' and therefore those describing such sexual abuse were not included in this study. This was a relatively arbitrary decision given the wide variability of individual physical and psychosexual development within the general population (Gariquet, 2005), but was an attempt to retain a relatively homogenous sample of '*childhood* sexual abuse' survivors.

2.2.4. Sample characteristics

All participants were female and currently lived in the North London area. The age range was 32-48. None of the participants was currently in full time employment. One participant was attending a college course. See Table 1 for further demographic details of participants. All participants had received prior psychotherapy. Three of four participants were beginning CBT for psychosis.

Clare

Clare[1] is a 35 year old woman. She was sexually abused weekly by her step-father from the age of 8 to around 13. She was also physically and emotionally abused and neglected, isolated from her siblings and bullied at school. She later suffered from psychosis in adulthood.

Jackie

Jackie is in her mid 30s. She was sexually abused by her father for a number of years when she was a child and adolescent. She has suffered several episodes of psychosis and of depression during her adulthood.

Irene

Irene is a woman in her early 30s. She has experienced several hospital admissions for psychosis during her twenties. She was sexually abused as a child by her grandfather. When she was younger she became anorexic.

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[1] All names have been changed to preserve anonymity.

Zoe

Zoe is a 48 year old woman. She was sexually abused by her uncle when she was very young. Sometimes it seems very difficult for Zoe to remember what actually happened during her childhood. In her adult years she has had a number of hospital admissions for psychosis.

Table 1: Participant Characteristics

Subjects / **Demographics**	**Clare**	**Jackie**	**Irene**	**Zoe**
Present Age	35	35	32	48
Sex	Female	Female	Female	Female
Ethnicity	White English	Mixed Race English	White European English	White English
Age at onset of Sexual Abuse	8 years	13years	9years	7years
Approximate Duration CSA	7-8 years	3-4 years	3-4 years	Unknown
CTQ sexual abuse score and range	25 (severe to extreme)	18 (severe to extreme)	15 (severe to extreme)	13 (severe to extreme)
Diagnosis/es	Bordeline Personality Disorder / Schizophrenia	Bipolar Affective Disorder	Anorexia - SchizoAffective Disorder Schizophrenia	Schizophrenia
Age at onset of psychosis	Mid-Twenties	Mid-Twenties	19	Mid-Thirties
Hospital Admissions	3	3	3	7
Psychotherapy (duration)	3years CBT for PD and previous group work	Beginning CBT for psychosis	Previous counselling. Beginning CBT for psychosis	Previous counselling Beginning CBT for psychosis

2.2.5. The setting of the study

Interviews were conducted within the psychology outpatient department at an NHS hospital in north London. Transcripts, and theme checking were conducted both at the hospital and at the University of Hertfordshire with the field and academic supervisors respectively.

2.3. ETHICAL ISSUES

2.3.1. Informed consent

Following identification of participants through the psychology department the clinical psychologist who worked with them briefly informed them of the study and asked if they might be willing to participate. If they replied, yes, participants were then phoned by me to again ask if they would be interested in taking part in the study and to answer any queries they may have about the interview process. At this point it was clearly stated that participants were under no obligation to take part and that the interviews would be informal, a chance to discuss issues about their current and past experiences, and that I would ask about childhood sexual abuse, but not about details of specific instances of abuse. If participants agreed an appointment was arranged over the telephone to meet at the psychology department (as they were familiar with this location). They were then sent the information sheet and an interview confirmation slip. At the interview, participants again had the study explained and were given the opportunity to ask any questions prior to consenting to take part. They were again given time to read a copy of the information sheet and to sign the consent form (see appendix C) if they wished.

2.3.2. Confidentiality

Participants were informed that any data collected about them would be kept strictly confidential. This meant that information about the participant which left the hospital such as transcript or demographic material/ information had the names and addresses removed. All transcripts of interviews were made anonymous and only distinguishable by a code to myself. Participants were informed that the thesis supervisors would have access to anonymised transcripts in order to help me with the project and data analysis. All audio-recordings were kept in a secure password protected portable hard drive. Participants were informed the audio-recordings would be destroyed after the thesis viva and the transcripts and paperwork destroyed after a maximum of five years.

On the participant information sheet (see appendix A) participants were informed that should they consent to take part their medical records might be accessed by me for basic demographic details. Participants were also informed that their names would not be disclosed to anyone apart from John Rhodes (field supervisor) and myself so as to maintain the confidentiality of audio recordings and transcripts. Additionally, it was discussed that I might ask the participants' permission to inform their care team that they had agreed to take part.

2.3.3. Implications for future treatment

Participants were told prior to, and at interview that they could withdraw from the study at any point. In the information sheet it was clearly stated that their participation or withdrawal from the study would in no way affect any future treatment participants might wish to receive from the psychology department.

2.3.4. Potential distress for participants

Answering questions about childhood experiences may be distressing as it can bring up painful memories. Prior to and during the interviews I repeatedly checked with participants how they were feeling in relation to our discussion, reminding them they could take a break if they wished. The structure of the interview aimed to gently introduce the topics of psychosis and CSA and not immediately focus on them. By the same token, I attempted to close interviews by considering strengths and positive aspects of the participants' lives and discussing everyday issues with them not related to the interview topics. In this way I hoped to draw participants away from any immediately potentially unpleasant thoughts and feelings potentially raised during the interview. I felt it was important not to simply leave participants to dwell on difficult experiences, if I could at all do so. In the end, many of the participants expressed that it had been useful to have the chance to discuss their childhood experiences, even if they were not always positive. Additionally, participants were offered further psychological input at the Psychology Department with field supervisor John Rhodes if the interview raised issues which they wished to discuss further. Prior to interview Irene expressly stated she wished John Rhodes to be present. This was agreed to, in order to honour our commitment to participants' psychological well being. This is discussed in greater detail in the Discussion under methodological limitations due to its implications for study design.

2.4. DATA COLLECTION

2.4.1 Procedure

Participants were invited to come for an interview at a time convenient to them, for example, when they considered they might be more relaxed and alert. For all participants this was around mid-afternoon. Just prior to the interview commencing participants were encouraged to feel free to talk as much as they wished and told that there were no right or wrong answers. In addition, I described how I might at times ask seemingly very obvious questions and that this was in an attempt to understand as best I could the participant's experiences.

Participants were informed at the initial telephone discussion and whilst re-reading the information sheet and consent form that they could withdraw from the study at any point they wished. Throughout the recruitment and initial phase of the interviews terms such as psychosis, delusions and hallucinations were avoided (Knight, 2003; Penn & Nowlin-Drummond, 2001). This was to avoid potentially alienating any participants who may have viewed their difficulties outside of a medicalised discourse. Later in the interview participants were asked if they had been given a diagnosis and what sense they made of that.

During each of the interviews I attempted to cover each of the main themes as outlined above by following a semi-structured interview schedule (See Appendix D). In all cases the interviews began with discussion of the participant's present situation and difficulties. This was to allow the participant to 'feel' their way into the interview and begin to engage with the interviewer. Also, I felt that discussing recent / current concerns would be easier to discuss for participants in terms of their feelings and thoughts and set the scene for discussion of particular and specific thoughts and feelings throughout the rest of the interview (a relatively well established technique within CBT). Following this first third of the interview, I then moved the discussion onto childhood experiences if the participant had not spontaneously done so. At this point participants were reminded they did not have to discuss any specific details of abuse if they did not wish to, but by the same token were free to do so. This part of the interview was assumed to be potentially more upsetting for participants and thus was positioned at a point in the interview to allow a substantial portion of time to come away from traumatic memories and to debrief. In the final third of the interview participants were asked to reflect on their experiences and how they construed their present and past difficulties. Participants were then asked about what was important for them now and in the future to draw the interview to a close and to regain a sense of their present situation. Finally, participants were asked how they were feeling, if they had any further questions or whether any issues had come up for them during the interview. This was deemed to be a debriefing measure to allow participants and interviewer to close their discussion satisfactorily.

2.4.2. Semi-structured interviews

Smith and Osborn (2003) regard the use of semi-structured interviews as the ‘exemplary’ method for IPA. They argue that this method allows both the participant and interviewer to engage in a flexible and dialogical process. In doing so, the interviewer can adjust his questions and focus the interview onto particularly rich or novel areas pertinent to the original research questions. The interviews in this study therefore followed a semi-structured format asking participants about the emotional and psychological effects (not the concrete or specific details unless participants wished to discuss these) of their childhood sexual abuse as well as current difficulties they faced including their psychotic symptoms. Each interview lasted approximately 60 to 90 minutes and was digitally audio recorded (using an Olympus VN 960 PC digital recorder) that was uploaded to a PC and later transcribed by the interviewer.

Participants were interviewed alone, although it was made clear in each case that they could bring a family member, friend or carer, but not if this constituted an original abuser. They were offered travel expenses but not any reimbursement for their time participating in the interview.

In the interview with ‘Irene’ she expressed that she only wished to undertake the interview in the presence of her therapist and my field supervisor John Rhodes. We therefore agreed to this change in methodology so as to include Irene in the study (this is also discussed in Chapter 4).

2.4.3. The interview schedule

Each interview attempted to cover three broad areas although remained flexible in allowing for participants to discuss areas of interest and importance to them. This was to allow me to cover areas pertinent to the key research questions but to increase the possibility of 'serendipitous findings' (Smith and Osborn, 2003) not foreseen by myself and which might enhance the study. Crucially, I also felt it was important to allow participants a strong share of the direction of the interview (See interview questions in appendix D).

2.5. DATA ANALYSIS

2.5.1 Analytic procedure

The data were analysed using IPA according to procedures outlined by Smith and Osborn (2003). First, interviews were transcribed by myself . Transcripts were then analysed one at a time. IPA is an 'idiographic' methodology, examining in detail an individual case, then moving onto another, building up a rich, novel, valid and detailed understanding of a small sample.

The first transcript was therefore read a number of times. At each reading the transcript was annotated moving from initial thoughts and ideas raised by the text to more detailed, interpretative and structured coding. Interpretative comments and researcher thoughts were re-checked with the text allowing the emergence of specific themes for the first participant. This process was repeated for the remaining three participants.

Once all four transcripts had a list of themes, these were then integrated and organised into headings and sub headings (See table 1). Throughout this process referral back to each of the individual texts kept interpretations close to the verbatim data (Smith et al., 1999; 2003, 2004). Themes were kept in the analysis according to prevalence within and across the four transcripts. However, prevalence was not the sole criterion for inclusion within the thematic hierarchy, with particularly rich or novel data also comprising themes (Smith and Osborn, 2003; Knight et al., 2003).

Although analysis of all the transcripts was undertaken by myself, two clinical psychologists experienced in IPA reviewed one of the analysed transcripts and the table of themes in order to help confirm the clarity and logical progression of the audit trail (See Appendix F).

2.6. WRITING UP

Writing up started after analyzing all the interviews. The aim was to construct a narrative integration in which the themes were embedded with direct illustrative quotes from the texts. In doing so, I aimed to produce a concise, yet non-reductionist description of the accounts given by the participants. This then formed a platform to engage the ‘double hermeneutic’ (Smith, 1996) and move beyond mere description of the accounts. The narrative integration itself was produced via an iterative process back and forward from the interview texts, emergent themes, table of themes across participants, and checks by me and my supervisor. This process was important to avoid constructing themes that diverged excessively from the texts and / or conformed too rigidly to existing literature.

2.6.1. Validity and good practice in qualitative research

Peer review

My academic supervisor, and field supervisor (Pieter Nel), both have significant experience in IPA. My academic supervisor completed his Phd. Using the IPA methodology to explore the experiences of training to become a psychotherapist. He has supervised a number of IPA Clinical Psychology Theses, and works clinically from a broadly systemic and constructivist position. My field supervisor (John Rhodes) has published a number of journal articles using the IPA methodology. Working clinically with people suffering from psychosis he has used IPA to explore the relationship between psychotic content and life stresses / concerns of participants. His research work is broadly from a realist position. Both supervisors read an interview transcript and drafts of thematic tables and results section. The academic supervisor felt that my initial annotations were too close to the original text and urged me to be more interpretative / use my own perspective in the right hand column of the transcripts. Both supervisors felt that early groups of themes required further rationalization, with simplified language and descriptions. They also separately urged my thematic organization to move away from rigidly clustering around the three main research questions, favouring a more integrated approach. A further female clinical psychology trainee also undertaking her first unrelated IPA project felt that some of the more interpretative material should be moved to the discussion section. Finally, another female, person-centred counselor unschooled in IPA, but familiar with psychological research, gave her perspective both on the overall structure and layout of the thematic table and results section. Each of the reviewers described being able to follow the logic and layout of the themes and tables.

Post-interview member 'validation'

Following transcription and coding of the interviews a brief summary of each interview was written up (see Appendix E). This again helped me to consolidate my understanding of each of the participant's accounts. Significantly though, the main purpose of the narrative summaries was to potentially re-connect the participants with their own data and to consolidate 'face validity' of the study itself in accordance with good practice in qualitative research generally (Elliot, 1999; Horsburgh, 1993) and in IPA specifically (Smith, 2003).

There are strong philosophical grounds for holding that language may not be verifiably proven as corresponding to an 'objective' truth regardless of the number of occasions a participant is interviewed (Devitt and Sterelny, 1999). However, despite this I felt it was important to try and include disagreement with my position in order to adequately respect the participants' involvement in the research process (Oliver et al., 2004). Additionally I hoped feedback might spur my own thinking about the entire project during the discussion and conclusions (Smith and Osborn, 2003). In the end, none of the participants returned details of agreement or disagreement with the summaries.

2.6.2. Reflecting on my own perspective

Willig (2001) describes personal reflexivity as a researcher reflecting on their own experiences, beliefs, values, political stance, wider contextual issues, and how these may have come to influence their research. What follows is my attempt to draw together some of these issues in relation to my own experiences in and around this research project. IPA makes no explicit assumptions about how a researcher incorporates this within their research programme although personal reflexivity is considered an important element of the theoretical rigour of IPA (Smith, 1996, 2003, 2004).

2.6.3. Reflecting on interviewing, transcribing and coding

Although curious, I was also a bit reluctant to begin the process of asking people about their childhood sexual abuse. I was not sure whether I would be able to adequately hear painful details of abuse. In my previous experience I had heard about terrible childhoods and also developed some understanding of the experiences people have of psychosis. I had not worked with people specifically about their abuse however.

In addition, I was markedly concerned regarding being a male and asking women about the abuse they had suffered by males. Initially I worried that this could be traumatic for the participants, and that it might make it more difficult to talk to me about their experiences. From discussion with my supervisors I began to feel that, given the ethical steps put in place to minimize possible participant distress, my fears may be exaggerated. In interviewing the women I found them to be seemingly unconcerned with any difficulties in relation to talking with a man, although this may have been an issue for some of the women who chose not to participate. I feel that although this question should always be considered, the main issue is whether a researcher is respectful of his participants ethically, methodologically and interpersonally.

In general, my lack of experience made developing a semi-structured questionnaire difficult for me, and trying to put down how I might word questions around the abuse, or bring the subject up within an interview felt awkward. My own reservations about somehow forcing people to divulge and relive painful abusive experience meant that for me, I felt I should communicate to people that the aim of the study was not to explore in details the 'facts' of the abuse but rather, in the spirit of qualitative research explore the meaning of those experiences for people. This allowed me to develop an interview and a position in which I felt safe to go forward and ask people about their experiences.

Interviewing itself proved to be less problematic than I had anticipated as I drew on my experiences of work throughout my clinical training to try to engage and listen adequately to participants. At times I found it difficult letting go of some of the concern to be therapeutic, which may have shifted me away from some details pertinent to the research agenda.

After transcribing the first interview I adopted an anxious avoidant state regarding the transcripts. I actually found it difficult to re-engage with the first text having transcribed it a number of weeks previously. Some of the details from the account had played on my mind as particularly horrible and at one point it was important to ‘check-in’ with my field supervisor about this. Again though, several weeks passed and I’d found myself disconnected from the thesis project, preferring to think about other things. I now think some of my procrastination and avoidance derived from the interview content. Engaging with the interviews repeatedly and reading further into some concepts from the relevant literature such as dissociation and disconnection, somehow resonated with my own response to the ‘words on paper’ I’d transcribed. This led me to reflect: ‘If I’m disconnected from this stuff, how must it be for those who’ve lived it?’

CHAPTER 3: RESULTS

3.1. Introduction

This chapter is a narrative account of the three super-ordinate themes that I have constructed through repeated engagement with and analysis of the transcript data. Table 2. outlines the four super-ordinate themes which are: 'interpersonal difficulties', 'striving to get better' and 'a relationship with shame' and 'links between CSA and psychosis'. Each of these is made up of further themes that will be discussed in detail below using relevant extracts taken from the texts. This chapter remains firmly grounded in the textual data and provides a platform from which conclusions and implications may be drawn and considered in the Discussion chapter.

Table 2. Themes and Superordinate themes across all participants.

3.2. INTERPERSONAL DIFFICULTIES	**3.3. STRIVING TO GET BETTER**	**3.4. A RELATIONSHIP WITH SHAME**	**3.5 LINKS BETWEEN MENTAL HEALTH, CSA & PSYCHOSIS**
3.2.1. Difficulties being with others	3.3.1. Attempting to cope with feeling bad	3.4.1. Internalising shamefulness	3.5.1 Links between CSA & Mental Health
3.2.2. Negative experiences of others	3.3.2. Navigating relapse and recovery	3.4.2. Apportioning blame	3.5.2. Links between CSA & Psychosis
3.2.3. Living in fearful isolation	3.3.3. Learning to take a stand	3.4.3. The shame of others?	3.5.3. Psychosis and Shame (implicit linkage)
3.2.4. Feeling stuck	3.3.4. Attempting to make sense of experience		

3.2. INTERPERSONAL DIFFICULTIES

This first theme outlines the way in which participants described finding it difficult relating to other people in their lives at different places and times. Sometimes this was in relation to family members and partners. At other times, being in the company of other people, members of the public or health professionals could promote a deep sense of anxiety, discomfort and pain for participants.

Often this was tied to a sense in which other people were perceived in a negative light. Participants described how, in their experience, it was often difficult to trust people, that others have questionable motives, are false, hypocritical and likely to disappoint or even hurt them. These negative experiences with others often led participants to feel extremely angry about their treatment by others.

Each of the participants described in their own ways a degree of withdrawal and isolation that they had purposefully adopted in response to their distrust of others. Sometimes this was discussed in relation to life at or around the time of the sexual abuse itself, often with added complications of going to school and the difficulties and challenges of childhood. At other times, participants talked of their experiences in relation to psychosis and mental illness.

Participants also spoke about their current day to day isolation from others as a valuable strategy for minimising discomfort and distress brought on by difficult interactions, but also contributing to a sense of loneliness that could be difficult to break out of. The isolation that participants described therefore often made it yet harder for them to interact with others.

Finally, in this theme, participants described a sense in which their difficulties with others, their withdrawal and isolation contributed to a sense of feeling stuck in their lives, of not moving forward and of being on the outside of life, looking in. It left them with a feeling of being ‘other’, or the odd one out, and of being stuck at ‘square one’ or even ‘crippled’.

3.2.1. Difficulties being with others

In this first sub-theme, participants described their difficulties being in the company of other people. Jackie, Irene and Zoe described early on in their interviews an explicit sense in which they were avoidant of people in general.

> *I don’t really like going out in crowds. I get nervous around people. I’m shy. Jackie P41.*

> *Coz I’m not good round crowds of people. I suffer from agoraphobia. Irene P11.*

> *I find members of the public very difficult to deal with. I find people are very aggressive very judgemental you know? And I sometimes just wanna withdraw from people. Zoe P3.*

Zoe felt that she was a shy person and that she had a great deal of difficulty interacting with people. She also described how a recent abusive relationship had further eroded her trust in others.

> *I think I'm quite a shy person by nature, and I don't know what makes me shy…Zoe P19*

Zoe went on to describe that her discomfort with others had also reached right into the heart of an intimate relationship she had had in adulthood.

> *I was terrified of sexual contact with him, you know, I just didn't want it at all. And then we used to have problems towards the end. Zoe P31.*

Zoe also described how her current situation was one of significant difficulty keeping others to some degree at the level of acquaintances, to avoid potentially being hurt or let down by them.

> *I'm very much on my own a lot of the time. Apart from centres, but I don't want to get too close to people, so I just don't want to, you know? I find it difficult. Zoe P11.*

> *I had friends at school, but it was just like I had this dirty secret all the time. And I hardly went to school. I used to stay at home with my mum a lot. Jackie P16*

3.2.2. Negative experiences of others

This second sub-theme highlights some of the negative experiences which may have caused or resulted from the difficulties described above. Both Clare and Irene had experienced significant and painful disappointment at the hands of their families and an array of ‘professionals’ over the years, including the education system, social services and mental health services. For Irene, these negative experiences in relation to professionals were a significant source of anger. This frustration and anger with others seemed closely tied to a feeling that so called ‘professionals’ had failed to help her put an end to her abusive environment quickly, therefore subjecting her to even more needless torment.

> *I’m angry with the people for putting the fear of god into me, for not believing me. Em, to me for allowing the sexual abuse to continue to have happened, eh, for the bullying. I’m angry with the people for not, for them being false. Irene P46*

For Irene, negative experiences with professionals such as psychologists and social workers has led to a sense of deep distrust of the ways in which professionals relate to service users.

> *It’s the seniority [sic] that makes me want to throw up when they ‘ oh, we know about this and we know about that and we know about this.’ To me you know jack S.H.I.T Irene P15*

Clare described a similar disappointment in her treatment by services at the time she was being sexually abused. Here she illustrates, not only her efforts and disappointments, but something of the personal legacy left for her to deal with in her adult years.

> *I put myself into care when I was sixteen, and I reported to the police, the social services, the NSPCC, everything that I could remember from what had happened to me and em, they seemed not to believe me. They seemed to do nothing. And all they really did was put me in care. And then when I was eighteen I was left to my own devices on my own, no friends, no family, no help. And em, I felt totally let down by the system, and em, not believed, not understood, not appreciated, yeah, not trusted. All these things that I've been feeling for so many years. Clare P3.*

Clare went on to describe how her negative experiences, despite being put into 'care' further strengthened her decision to withdraw and isolate herself, as she had done in the abusive family environment.

> *Well if you're not gonna listen to me, you're not gonna believe me, you're not gonna trust me, I don't want to know you. And so I isolated myself, eh, for many years, wouldn't meet people. Wouldn't talk to people. Would literally ignore people. Clare P4.*

Zoe also spoke about the extent to which confusion could arise in relation to her distrust of other people. This often seemed tied to whether their motives might be harmful in some way.

> *I get confused, I get really really confused over people's motives.*
>
> *Zoe P32.*

> *And it's all confusing you don't know whether it's reality or not sometimes, but I could tell by the tone of his voice he wasn't very nice, he was being very aggressive whoever it was. Zoe P1.*

3.2.3. Living in fearful isolation

In this third sub-theme, negative experiences and difficulties in interaction seemed to combine to lead participants to withdraw from others both physically and emotionally. Clare described this process at a time when she was a child (just after sexual and physical abuse had been perpetrated against her).

> *And eh, so I went into my room, and I sat there and I cried and cried and cried. And I think from that moment on I just decided even if it happens again I'll never tell anybody. Clare P8 .*

Clare also described the crippling fear that she experienced almost all the time while she was a young person, enduring regular sexual abuse in her home for a number of years, as well as relentless bullying at school. For her, both had been linked through her family's neglectful and abusive attitude to her, so that she went to school in unclean and inexpensive clothing with an unbearable weight of abuse and silence upon her making it simply impossible to be a normal child. This emphasises research that has found that CSA never occurs on its own. Fergusson and Mullen (1999) report evidence of up to 40% of sexually abused children also having been subjected to physical and or emotional abuse.

> *I was just totally, I was frightened. That's all I was. I was just frightened all the time. So I'd be like cowering in corners. And em, never saying anything. Clare P9- 10*

At another point in her life, Clare described how psychosis and mental illness had led her to drop many of the aspects of her life that connected her to others. Herman (1992) describes the process of disconnection from others and self as being a common coping mechanism in survivors of CSA.

> *My finances, my home, my work, my friendships, my relationship, everything. I lost control of it all. And so, because I had isolated myself, I had gone far away from myself. I'd sort of left myself. I didn't want to be myself. I had done everything to get away from being me. Clare P20.*

Clare later described how feeling fearful eventually led her to believe that her unusual or psychotic experiences were ‘real’. From her present vantage point, Clare described making a distinction between the reality or unreality of certain events, by reference to her experience of the world. But she emphasised that when she was fearful it was a different story altogether.

> *… at the time you totally believe it and you’re totally frightened. And I think that fear, it sort of has, it makes you believe that, that it’s real. Clare P18.*

> *No I actually could sense it. I could sense it all happening. Around me as well. It’s like I could sense it was all real. I didn’t have to hear or listen to the voices. Jackie. P11.*

> *It was petrifying. At one point I was seeing a man at the window pointing a gun at us all and I threw myself on the floor. Jackie P12.*

Zoe spoke more generally and more currently about some of the fear she faced in relating to other people. For her, people in general could sometimes be malevolent and untrustworthy. This could lead to a sense of despair or futility about engaging in almost any form of interaction with others.

> *That's how I feel. It's like a negative attitude and I'm frightened if I have a rare day when I want to talk to someone I feel that there's some motive behind, eh, something. You know, I feel like people are hypocritical, they're nice to your face and they say things behind your back. You know, I think well what's the point of talking to people sometimes. You know, what's the point? Zoe P2.*

On the other hand, Zoe also described a sense in which she had yearned for contact with others, even with someone who had been abusive to her in adulthood. The confusion engendered by wanting to keep people away, but at the same time yearning for human contact, led Zoe to sometimes doubt her own mental faculties.

> *I mean, I don't know if my brain cells have gone, but at times I sort of missed him because I felt so lonely and isolated, you know? Zoe P6.*

3.2.4. Feeling stuck

The final sub-theme of 'interpersonal difficulties' outlines how the above issues about difficulties with others, negative experiences of people and a need to isolate and withdraw oneself had led participants to a feeling of being stuck in participants' lives. Jackie talked about assertiveness and confidence, and how throughout her life she had felt short on both. She linked this to her abusive past, describing how a person learns to live within an unchangeable situation.

> *I think it might be the assertiveness. Like living with something that you can't make, you know you can't change. You're forced to live in that circumstance where you can't change it or…Jackie P39.*

> *Eh, it's just myself. I find it hard to socialise or move on with my life or like start up a course or something like that. I don't think I'd ever have the confidence to do that. And em, I dunno really. Jackie P5.*

Irene also described feeling stuck. For her there was considerable anger at being in this position, which she believed resulted from both the sexual abuse and her painfully unsuccessful interactions with various professionals. She described her life at the moment as:

> *A pile of shit. I don't see my life. This is just existing. This is not living. I'm angry. Irene P18.*

Irene described the difference for her between existing and living. For her it was about the ability to participate in various aspects of life and therefore being a member of society that has things, as opposed to being on the outside, not having things.

> *I just want what other people have got. Family, house, job. But what stops me, my friend's completely right is being angry. It's only gonna eat away inside you, it's only gonna make you bitter. Irene P45.*

Clare, too, reflected how she had not lived the kind of life that she felt other people live.

> *Basically, I haven't been able to live a normal life. Clare P4*

For her, a normal life seemed to relate to her own relationship to herself. She described normality as being:

> *...able to communicate, able to work, able to have sort of a sense of myself. Clare P19.*

Towards the end of her interview, Irene reflected that there was something else in addition to her anger that was contributing to her sense of being stuck in her life. For her there was also considerable fear about achieving things, which carries its own risks in relation to trusting both oneself and others to carry out tasks.

> *...it's a fear of achieving that, em, for me to achieve what I want, there's always a fear that it's not gonna come to fruitation [sic], because in my life there's always gonna be someone that's gonna destroy it. Irene P46*

Zoe also reflected on her concerns about feeling stuck. For her, there was a worry in acquiescing, for example, in attending a certain day centre indefinitely. On the other hand, much like Irene, there were difficulties attached to moving out of being stuck, in this case a sense of failure.

> *But then I used to feel a bit anxious that I couldn't move on from there you know. I tried different things and they didn't seem to work out. You know, attempted things. Zoe P15*

Clare elegantly explained her experiences of psychosis and the process of 'buying into' to the point of 'no coming back'. Here she emphasised how one can, by a step-by-step process, reach psychosis, itself a desolate, isolated and stuck position.

> *It's like, when you're alive, when you're living you have all these thoughts and feelings and you can be quite realistic. And you can be intuitive and understand and know what's going on around you. But then you have these psychotic experiences where you really don't know what's going on. You're just reading, everything that's going on in your mind you're, you're buying into it, you know? And each thought is a new thing to buy into. The more you buy into it, the further down the illness track you're gonna get. You know? And once you get down that track so far at certain points there's no coming back. You know? Clare P14.*

3.3. STRIVING TO GET BETTER

This second super-ordinate theme attempts to convey the often complex and ongoing responses of participants to their own problems in living. In response to pervasive and insidious negative feelings and thoughts, participants seemed to describe two broad approaches. The first one could be seen as closely linked to a kind of 'dissociative' drive away from pain; a kind of experiential avoidance. This could be both short term and immediate tactics or longer term 'ways of being' to deal with psychological, emotional and physical pain.

The second major approach that each of the participants described seemed more directed towards long term healing. For some, this may also have remained at a 'tactical' level given their resources and the degree to which current environmental or interpersonal difficulties impeded their efforts. For others, a more 'strategic' approach could be discerned in their accounts of remission and recovering.

3.3.1. Attempting to cope with feeling bad

This first sub-theme describes the immediate or quick acting methods participants described utilizing in order to avoid experiencing physical, emotional or psychological pain. Jackie described how her attempts to feel better often involved drinking alcohol. For her the evenings signalled an increase in anxiety and negative thoughts. She needed something that would help give her some space from her difficulties. She used alcohol …

> *I think just to blank things out. Make things feel happy, in myself and blank out the night times. I used to drink until I could fall asleep with no problems. Jackie P31.*

I asked Zoe about her feelings in relation to the diagnostic label she had been given in response she seemed to describe a similar process of blanking out or diverting certain emotional or psychological experiences, this time into her body.

> *I sort of divert it from, I just, it's all in my body. It's peculiar, it's sort of like a numb feeling, yet at the same time, I can't explain it, it's very difficult to explain. Zoe P15*

Zoe had also employed alcohol at various times in her life. For her it was more related to drinking with others, as a way of bypassing her shyness or social anxiety and being more able to get on well with people. For Zoe, perhaps like Jackie, the use of alcohol as a short term tactic sometimes had further negative consequences.

> *When I've had these problems with drinking I was finding it a bit easier to talk to people but then I got into a situation I didn't want to get into. Zoe P19.*

This was reflected in Zoe also describing how she was trying not to drink, so as to avoid putting herself into vulnerable situations in the future. For Jackie, there was a greater acceptance of the ongoing place for alcohol in her life.

> *Once I got my own place I felt like freedom and…it was exciting, I was excited and I was doing all the wrong things…Jackie P30.*

> *I'll always have a problem with the bottle I think. I like my drink. Jackie P43*

Zoe described how her isolation, loneliness and her attempts to bypass her social anxiety with alcohol could lead her into situations potentially depleting her of further personal resources.

> *I think I was so, not very well at the time when I was, out of fear bringing people into my flat. You know, being frightened of being on my own. And feeling like they took everything. They took things from me. It wasn't material things they took from me, I felt like it was an emotional strain as well. Zoe P32.*

Jackie described how from years of hiding her experiences of being sexually abused she had developed a way of being that aimed to blank out psychological pain. This seemed a broader approach to life, in which using alcohol would later fit in well as a useful dissociative tool. In her teens Jackie had been raped by a young male. This occurred a short period of time after the cessation of familial abuse perpetrated against her. She fell pregnant, leaving her with something she felt she again had to hide.

> *Well, it's like carrying on like everything was normal. But deep down I had this f…well a baby and it was a feeling inside of me that I wanted to tell somebody but I couldn't. It wasn't the same sort of thing, but it was, like I had a secret again……, it seemed like I could keep it more of a secret, coz I'm so used to keeping that as a secret for so many years. I'd feel like, you know, I just would blank it out and make out everything was normal. Jackie P26.*

This experience of 'retraumatization' and vulnerability to further abuse has been found in the literature, with survivors of childhood abuse being more likely to be abused in adulthood (Cloitre et al 2001; Muenzenmaier et al. 1993; Noll, 2005). However, Jackie describes something further, in that her ability to access resources seemed curtailed by her experiences of silently holding onto pain. In this sense, the pain of further sexual trauma and the fear of its consequences further isolated Jackie from others. Her attempts to blank out experience seemed the best, most useful strategy given the inability of her environment to accept or unburden her from her pain. This personal and silent carrying of pain may reflect some aspects of wider gender stereotypes of women being able to or having to put up with pain (Busfield, 1996). In addition, the habit of 'keeping a secret' may be a specific mechanism by which survivors of CSA come to deal primarily privately with suffering, making accessing help or resources an extremely unfamiliar activity, perhaps perpetuating isolation and vulnerability.

Irene explained how her own private coping was bolstered by her sense of having a kind of spiritual guardian. This may also reflect, like Jackie, the limited resources available to her in her immediate environment. For Jackie, the private matter of coping came about through her expertise in holding onto painful secrets yet blanking out the pain by using alcohol. In a more immediate and everyday sense, Zoe described a process where she tried to use logic to reassure herself that things were ok. For her, some respite could be gained by checking and using a reasoned approach, but often this respite was short lived.

> *You know, sort of thinking someone might come in and assault me. But em, then I try and logicalize [sic] it, and I think 'is it possible, if they get through my roof, if they get through my door?' and I sort of check, I do that during the day as well.... Eh, sometimes and then I drift off into the same patterns of thought again. Zoe P14.*

3.3.2. Navigating relapse and recovery

In this second sub-theme all of the participants described a process of navigating their way through innumerable difficult and painful experiences. This particularly illustrates how recovery is not a state but a process, such as in the 'recovering' psychosis literature (Davidson, 2003). Gains in mental health and feeling better seemed hard won and potentially extremely vulnerable to decay or loss. This gave a further sense of insecurity and uncertainty to the lives of the participants.

> *When I was ill, I mean, I say when I was ill but I probably am over it now, I don't know coz I'm still on medication. Whenever I come off it I seem to have these experiences. Clare P18.*

Clare articulated a dialectical process of recovery. Dialectic here is taken to describe a dynamic and evolving process involving cyclical shifts through relapse, change and recovery. It is used to express a progression towards recovering that does not posit rigid 'stages' of recovery. In this context then, Clare described how she experienced increased well-being and self understanding that would not allow her to be at the mercy of her psychoses as she had been in the past. On the other hand, her understanding of the *experience* of psychosis, of the severity and force of it, meant that she could doubt whether her more self aware mind could withstand it.

> *I am worried that in the future I will get sick again, even though I've got to a stage where I feel like, sometimes I feel like I can't go back to that. It, it's just not possible now. I've learnt too much about myself, I've talked about my experiences and to the point where I've understood them better. And, em, and just sort of, and I've learnt about sort of cognitive, em, behaviour, you know so. Em I thought I have more control now than I had before. So, I hope that there won't be any more incidents in the*

> *future but I don't think that's possible. I don't think, I think it doesn't really matter where you are in your mind, if you're sick, you're sick. And, and that is a worry. Clare P19-20.*

Clare closed her description of the dialectic of recovery in terms of positioning different parts of her self. In particular she uses a distinction I / me to describe a process by which the 'I' approaches and allies itself with 'me' in a state of recovery aiding her to understand and own her experiences.

> *It's like you've gone so far away from yourself that you've had this experience, yeh? But now, I've come much closer to myself, so I know that I'm having the experience. Clare P19*

Irene described her own relationship to recovery, her own path. Firstly, she described her feelings about counselling. Despite undertaking more therapeutic work at the current time, Irene outlined some of her misgivings about such an approach:

> *When I like get counselling I thought to myself, oh god counselling yet again, what am I gonna get out of it. It's like climbing up one mountain, thinking you've got to the summit, and then you've got to climb up the mountain. I think to myself why do I bother. Irene P29.*

Zoe also described a pattern in which she felt herself drifting in and out of feeling better and worse, her worries about relapsing and her day by day attempts to stay out of hospital.

> *I'm relieved that I don't go there anymore. But there's been in the last week or so, I felt 'oh I feel so bad' I thought I'm gonna end up back in there again. But, I'm managing, trying to maintain being out of there, you know? Zoe P12.*

Jackie described a process by which she had come to realise from the point of view of her own health that she needed to let go of some of her angry feelings towards someone who had caused her and her daughter immense pain and suffering.

> *Yeh, that's all over now, but, I still think back with anger. I still feel I could still kill him, but I've had to calm meself [sic] down, coz I know it ain't no good for me. Jackie P35.*

She also described how her attempts at feeling better have always had a darker background to them. Here Jackie uses a phrase 'black cloud' over her that has marred her attempts to be happy. She also used similar imagery when talking about what would happen to her abuser when he abused her.

> *I've had a few happy times .... But I've always had that black cloud over me that's a struggle to be happy. Jackie P3*

> *It was like something, a cloud came over him and he didn't know what he was doing, and I don't know what was going on, but it was frightening, and that was horrible, a horrible experience. P15*

Like Clare, Jackie, perhaps because of the weight of the ever present black cloud, described the fragility of her mental health and her uncertainty as to whether she might become unwell again.

> *I don't feel mentally stable anymore. I don't feel, I feel like my mental health's deteriorating, type thing. I feel like I might have another break-down, well not another break-down but something's not right with my head nowadays. Jackie P4*

3.3.3. Attempting to make sense of experience

In this third sub-theme each of the participants described processes whereby they attempted to understand what had happened to them. They were trying to make sense of everyday life, psychotic experiences and sexual abuse perpetrated against them in childhood. These were not always separated out as the above sentence has done. For instance, *Z*oe spoke about a blurring of boundaries where she described a difficulty making sense of her interactions with her support worker, who helped to motivate and get her out of the house.

> *I don't know if the motivation is coming from me or if it's coming from her, I don't know. I just don't know. Zoe P8*

> *I get confused as to whether it's a mental health problem or a physical health problem…Zoe P8*

Clare talked about her confusion, particularly in relation to some of the experiences – described as 'psychosis' – that she'd had. For her, this had called into question the very veracity of things and of her self. This confusion, with no explanations either from others or her self, fuelled her sense of fear.

> *You know, nobody's helped me to understand it. Em, so I have no real understanding of it. I just have these memories, awful memories of things that have happened. And no understanding of why they've happened or how they've happened, or what it means for me personally. I don't really understand it. I just, it frightens me. Clare P18.*

Jackie also described her sense of a terrible significance through a number of negative events that had happened to her. She spoke about her own thinking losing its sense of reality and her experiencing of ‘apophanies’ , i.e. making meaningful connections that don't exist outside of thought.

> *I just thought it was all coming together, and it was all for a reason, and I’d been cursed. It was just awful I was thinking not, you know, not real at all. Jackie P7*

> *I know nothing was real. You know, nothing that I thought was going on was going on at the time. It was all like a dream. Jackie P13*

Clare described a related process in her life, where her sustained attempts at getting words out, of communicating with others in groups and psychotherapy had helped her to gain some crucial perspective on her own thoughts, linking on from her I / me distinction.

> *Yeh, you say it out loud and it just sounds so different to the way it is in your mind. Yeh? And then you think ‘hang on, that sounds really mad’ and then you can start to understand it. Start to look at it and think about it. And when you’re able to do that you’re in a totally different place from that place where you’re having those psychotic experiences. Clare P19.*

Here, there seems to be a distinction between inner and outer narratives, as if Clare experiences, or rather is now able to experience herself afresh from different standpoints. Firstly, she chooses to employ the second person perspective, outlining a generalised process, *'you say it out loud';* something that potentially another can go through, emphasising her own altered standpoint. This is further outlined: *'hang on, that sounds…'* as if she checks herself in thought, i.e. there is a discrepancy between her own speech acts and her own internal observation of those speech acts. Here Clare is reclaiming her own self through the reclamation of individual speech acts. She has turned back to herself in this way, perhaps in opposition to the 'turning away' of minds (of her and her family's minds) from abusive or unpleasant psychotic phenomena. Clare is reintegrating them, her "I" is being brought back into line with her "me". She underlines the separation by her use of geography, of *'place'*; when she reclaims the *'place'* from which to look, and therefore to think and finally to *'start'* to understand. She makes her own meaning (Crossley, 2000) through linking parts of herself to other parts of herself. Clare's tentative recovery of her own geography in this excerpt captures her own previous sense of being lost (inside herself) and of her journey towards getting better.

3.3.4. Learning to take a stand

The participants described how sometimes the only way they could get through each day was to fight, either with themselves or with other people in their lives who were not acting in their interests. Jackie talked about her daily struggles with depression, and how she simply had to battle through each day. Something in her, some quality, some belief would not allow her to give up:

> *Eh, I just get up and do what's gotta be done for the day. And that's it really. Sometimes it's a struggle to do daily tasks and that. But I try and get most of it done, push myself really. Jackie P2.*

> *Yeh, sort of, I've gotta keep going, I've gotta keep doing what I've got to do. Coz I don't want to really give up. I don't want to just give up really. Jackie P3.*

Some of the women also spoke about a self (belief) that helped them to fight or to hold on, even in the midst of psychosis and despair. Jackie again:

> *And I thought I was gonna go to prison, and that I should hang myself or put myself under a train or… and the voices were telling me I should do that. But it was me, and my self belief 'but I'm not' that stopped me from doing that. Jackie P9.*

> *I remember waiting for the train. And when it came, I just told myself 'well I'm not, I know I'm not, and I'm gonna prove that I'm not' [a paedophile] and that's when I didn't throw myself under the train, but it was really em, really frightening. Jackie P10.*

Zoe spoke of a similar inner strength and self belief. After months of being subjected to physical and emotional abuse in a recent relationship, she became more assertive.

> *I knew he was hypocritical, coz he was talking about me. So I was like 'I know what you're like you're just a total and utter hypocrite.' And I, I, swore at him to just get rid of him. I said 'the police have been informed about you.' Zoe P18*

Participants also described how they experienced an increased sense of self efficacy in their own lives. This was described in terms of control and re-appropriating experience. Jackie described at the end of her interview, perhaps reflecting some of the benefit of discussing and reviewing her experiences, an increased sense of agency and control, but one still coloured by depression:

> *Yeh, I'm feeling more in control of myself. Looking over the years now, I feel more in control. But I still feel pretty down and depressed, but I do feel more in control nowadays than I did years ago. Feel like I'm getting my own life back a little bit. Jackie P40.*

> *… But now, I've started sticking up for myself saying 'no sorry I can't do that' or…I feel more in control of meself. A little bit more happier, not feeling so trapped into things. Jackie P41.*

Irene discussed how she drew on her experiences to define herself, rather than letting medical discourses such as illness and diagnosis define her. In her account, she draws power through claiming back her own experiences.

> *People like to label other people. You cannot tell me something, when you know nothing about it. What I've gone through in my life is my experience. I've gone through it. You cannot call me something that I'm not. Irene P40.*

3.4. A RELATIONSHIP WITH SHAME

This theme comprises the participants' talk of issues surrounding shame from a number of perspectives. Participants spoke about issues around internalized shame. They also spoke of blame, either of themselves, through their childhood understandings of what had happened to them or their later feelings about themselves as adults. There were also issues concerning blame in relation to the abusers and other family members who may have colluded with the abuse. Finally, an issue also arose in the text in relation to some of the participants having described their childhoods as sheltered or protected. An apparent irony here led me to consider the role of shame as played out by the dominating and silencing role of the abusive and or colluding family members.

3.4.1. Internalising Shame

Towards the end of her account, Jackie described a sense in which she had been tarnished by her experiences of childhood sexual abuse. She talked about an inescapable feeling of being dirty. No matter what she did, a sense of feeling clean could not be achieved. She linked this also to her sense of being the odd one out, her experiences of abuse having perhaps irrevocably separated her from others.

> *I used to go to school and feel dirty. And em… I didn't feel confident enough. Jackie P16*

> *I still feel dirty, no matter how many times I have a bath... I still feel that dirty feeling, yeah. I do feel like the odd one out at times. Jackie, P41-42*

3.4.2. Apportioning blame

This sub-theme discusses issues around the blaming of others and of self that emerged from the women's accounts. The picture is often a subtle and nuanced representation of the participants' relationship to blame, both interpersonally through their experiences of abuse but also of their caring for others later in adulthood.

Jackie talked about blame, in relation to a sense of ambivalence she felt concerning the actions of her mother. In this extract, arguably Jackie's account de-emphasised her anger at her mother and family for effectively excusing the sexual abuse, perhaps reflecting some of the absence of assertiveness mentioned above. Her mother, someone who protected her, who was angry when she discovered the abuse and who fitted a lock to Jackie's door, was also someone who had not noticed, or perhaps avoided noticing for a period of years the abuse that Jackie was suffering. This was despite having known about similar such abuse of her other elder daughters.

> *I love my mum dearly. And I think thank god for her, in that she did get it all stopped in the finish. But she, I feel she should have known, she should have looked out for me a little bit more, knowing what had happened to my sisters. So I do feel…but she said that she really didn't know, and she thought once it was all out in the open and my dad swore he'd never do it again and everything like that, they just took his word for it. But, yeah, I wish it had come out earlier on, I wouldn't have had to suffer for all them years, knowing that everybody knew what he was doing to the others. I do feel a bit angry about that. Apart from that, no I do love my mum, and she didn't agree with what he'd done, and she told him how wrong it was. And em, I think she done the best she could really in that situation. Jackie P19- 20*

For Jackie, notions of blame ran throughout her account of her sexual abuse and her psychosis and 'mistakes' she felt she had made throughout her life. Her descriptions of celebrating when she left the house in which she had been abused also had another side in that she felt she had gone too far, to the point of neglecting her daughter emotionally, even though her own childhood had been cut short.

> *Drinking enough, and smoking. I should have been there looking after my daughter more. Although I didn't leave her on her own or anything like that. I wish I'd just concentrated on the last few years of bringing her up through her adulthood. But instead I just wanted to party and be stupid. Jackie P30.*

Crucially for Jackie, the rape of her daughter, at the same age she had been when she was raped, was for her the trigger into a full blown psychotic episode. Jackie felt she had failed her daughter, despite her own knowledge, experience and determination to protect her. Everything came together in a cursed significance and she was enveloped in a psychotic rage fuelled by her sense of self blame that lasted months.

> *Yeh, that's what brought it all back to me, and she was the same age as me when it happened to me… that's when I had my big breakdown, the first psychotic episode…. It was all significant, and now I know it was just a coincidence really. Jackie P31*

Irene too spoke about the way in which despite trying to communicate with her family that abuse was occurring in front of them, somehow they were not able or willing to acknowledge its presence or her fear, something that was at the core of her severing emotional ties with her biological family. She uses a particular phrase to outline the way she tried to non-verbally communicate, perhaps because of the physical and psychological feelings of entrapment. The lack of success in accessing the support of her family through this method, may be related to Irene's anorexia, which she described earlier in terms of control, and perhaps the communication of her psychological and emotional pain.

> *To me there's a saying, the eyes are the window to the soul. And I was trying to show fear to people sat at that table that something was going on. Irene P24*

3.4.3. The Shame of Others?

In relation to shame, another aspect emerged from the participants' accounts. This represented a sense of the word sheltered, a word that I would often equate with protection, actually meaning something completely different in this context. Here, participants spoke of being sheltered or over-protected by parents, despite a certain irony that they had been anything but protected in their own homes.

> *Obviously coz I missed out a great deal in life you know. I feel I have. I've been over protected by my parents the majority, a lot of the time. Zoe P31.*

> *We always had to stay in, or…Mum was really strict, and so was my dad. He didn't like us going out at all, or socialising much. So I feel like I had a sheltered childhood really. Sheltered and kept away from everybody. We kept ourselves to ourselves [sigh, laugh]. Jackie P17.*

This kind of protection, from the point of view of the participants, I have taken to be another form of abuse of power, maintaining a sense of isolation and silence in the children, minimising any opportunities for the abuse to be discovered. In this sense a further side of shame emerges whereby parents dominated and isolated their own children, this time perhaps to protect themselves from the truth and potentially shaming consequences of their own actions. From my perspective this appeared as bitterly ironic considering the abuse the women had suffered. The shelter or protection they discussed seemed to be more a kind of deprivation. As a researcher and trainee clinical psychologist this raised issues for me regarding the acknowledgement of differences of opinion with a client. How might a therapist think about challenging or reframing client speech so as to avoid perpetuating or validating negative sequelae of trauma or missing an opportunity for therapeutic intervention? This is explored in more detail in Chapter 4.

3.5. LINKS BETWEEN CSA, MENTAL HEALTH & PSYCHOSIS

In this final section I have drawn together links made by participants either explicitly or implicitly between their experiences of childhood sexual abuse, mental health difficulties in general and unusual or psychotic experiences in particular. This section predominantly focuses on links between CSA & Psychosis. In relation to this participants discussed linkages in terms of purported genetic explanations, impact of abuse, felt or bodily experienced similarities, and meaning making. A final section reviews some of the more implicit ways participants spoke about the content of unusual experiences and how this may link particularly with shame saturated self images described by participants.

3.5.1. Links between CSA & Mental Health

Zoe explicitly described that she felt because of her experiences she found it very difficult to relate to or trust others. This might have formed a backdrop to her interactions with others.

> *Em, I find it difficult to trust people really, now. I find it very difficult coz of my experiences weren't very good. Zoe P7.*

Towards the end of her account, Zoe again explicitly stated how she felt the abusive experiences had impacted on her.

> *Eh, difficulty relating to people. Em, feeling I'm out of touch with things you know? Wondering if it's too late in my life, if I'll ever change and be happy. Just very isolated an isolated person really. And then, I've been taken advantage of aswell. And I'm very wary of what's happened, my experiences have not been good ones. Zoe P27*

Irene described in her account understanding how her abuse and other mental health problems were linked. Her understanding raised a concept of ‘control’ as a central issue; this was in terms of her abuse, subsequent mental health difficulties, sense of being stuck in life and let down by professionals.

> *When I went into psychiatric care is because of my past. It’s got everything to do with my past. I was anorexic, because I had no control of my life. Em, I wasn’t believed with what was happening when I was younger….with the sexual abuse. Irene P21 .*

Here there is an understanding of her mental health difficulties as products of her abusive past; of having ‘no control’. Anorexia is perhaps linked by Irene to the control of her own life and body. Irene might have attempted control of her own body to de-sexualise herself; perhaps to reclaim it for herself. When Irene says: *‘I wasn’t believed when I was younger’* in this context she seems to emphasise a disempowered childhood. It seems that Irene was forced to ‘show’ her family and others that something was wrong; by starving her own body, and making her internal suffering external, painfully vivid for all to see.

3.5.2 Links between Psychosis and CSA.

Jackie described that she felt that there must be some kind of link either genetic or psychological between her childhood experiences of abuse and her later psychotic episodes.

> *I've got a cousin who's not all there either. He lives in ***** and he's had psychotic episodes. And like my sister as well and me. So it could be a genetic thing. But I don't think the abuse has ever helped, coz when I ever do have a breakdown or when I really get down in thoughts, it's always about that. It makes me get down. Like if I get suicidal it's always thoughts about that. Jackie P38.*

Irene made sense of her own unusual experience with reference to her own personal spirituality. In this sense, Irene's unusual experience of her now dead grandfather literally entering her mind/body became an opportunity for understanding.

> *It might sound stupid, but to me, this happened. Em, my Grandfather came to me and said he did what he did. He sexually abused me because he was sexually abused himself. Irene P33.*

One difficulty for Irene was her difficulty in making sense of her unusual experiences and her feeling that a spiritual protector could have allowed harm to occur to her in the first place.

> *I feel that there's some presence with me. Looking out for me, protecting me. Where the hell they were when I was being sexually abused, I don't know. Irene P3.*

Clare had made it clear that she felt that the content of her psychotic experiences was not related to her family. However, she articulated another more physically felt way in which she felt the abuse and the psychosis were linked. Her mental health problems including psychosis and her abuse seemed linked through an experience of feeling physically and mentally 'crippled.'

> *Yeah, because basically the way I was abused was quite crippling. Em, it affected my body and my mind a little bit, you know…and that cripplingness. That feeling I had as a child. Of being crippled. Sort of downtrodden. I've had that in mental illness. I've had it so that literally my body is crippled. Where I can't walk properly. Or I can't see, or eh, hear things properly. Em, its sort of similar to being in that situation. Clare P12-13.*

3.5.3. Psychosis and Shame

This sub-theme relates specifically to the seemingly close fit articulated by participants between the content of their psychosis and notions of shame saturated selves. Zoe described an undefined negative quality that she felt she possessed which might have been related to her own pervasive sense of shame. In this context the accusation of being a 'paedophile' was placed upon her; arguably one of the most shame saturated labels in contemporary society. Her use of the phrase 'I thought' perhaps indicated that her own negative perceptions had shaped what she had heard.

> *I genuinely think people don't like me for some reason. And I don't know what it is about me, you know? I have no idea… there is a neighbour next door, and I thought he called me a paedophile… Zoe P3*

For Jackie, the stigma of being seen as a 'paedophile' also emerged. For her it was intimately bound up with her paranoid and psychotic thinking. In this instance, everybody seemed to be aware of her pariah status, thus amplifying the shame and stigma she felt to enormous proportions. It is worth noting here that neither women thought *themselves to be* paedophiles, simply that *others* thought they were, creating a perhaps blurred boundary between extreme paranoia and delusional belief.

> *I thought that I was a paedophile, and that everybody knew what I was…No I didn't think I was a paedophile, I thought everybody thought I was. Jackie P8*

> *I don't know I was sitting on the train, and these voices said, you're on the telly, you're in the newspapers. You and your partner are paedophiles. You've got it all on your computer, on the internet. Oh, it was awful. Jackie P33.*

In a similar way, some participants responded to abusive or psychotic experiences by employing logical reasoning that drew them towards concluding their own shamefulness was true. Clare articulated such a 'logic of shame' in the context of psychosis. She described an experience whereby:

> *…a woman was screaming and screaming and screaming and running away from me and keep looking back to make sure I'm not following her ... I couldn't remember anything about why she was screaming or why she was running away from me…I was thinking to myself 'oh, ... I must have done something really evil to this woman.' You know? For her to be running away. 'What did I do?' Clare P15-16.*

Clare spoke about how the logic of shame led her step by step towards its own logical conclusion, in this case, suicide. Fergusson and Mullen (1999) outline a number of recent studies that report extremely high odds ratios of adult suicidal behaviour following CSA (up to 74.0 in one study).

> *You're having all these thoughts…, where you're actually now thinking 'well, if I'm that evil, I must just kill myself now' you know? because I can't be evil. I don't want people to see me like that. I certainly don't want to be like that. So I'm, I'm just gonna kill myself. Clare P16.*

Zoe described a related logic of shame, this time in relation to her own sense of illness and physical deterioration. For her, a logical conclusion of this process would be humiliation.

> *I just worry that my mind's gonna deteriorate, and I'll end up being totally and utterly in the hands of someone else. Made to feel humiliated coz of my… being incapable. That's what I really worry about. Zoe P34.*

This chapter has attempted to remain grounded in the textual data, yet move beyond it by constructing themes from the text using my own interpretative stance as a researcher and trainee clinical psychologist. In the final chapter more consideration will be given to several of the key issues raised here. This section has attempted to draw the reader closer to a view of the participants' ways of being in the world, ways often characterised by extreme and persistent negative feelings of withdrawal, isolation and stuckness. Participants have had to engage the world from a narrowed and deskilled position. They described approaching themselves and others with a sense of shame. And yet, participants also retained or recovered positive attachments, goals and values. The following chapter will discuss these ways of being further by returning to the original research questions of this study as well as considering further implications of this research.

CHAPTER 4: DISCUSSION

4.1. INTRODUCTION

This chapter will begin with a brief discussion of the significance of this research project. This will then lead on to a re-examination of the initial research questions regarding the participants' experiences of CSA and psychosis. This chapter will also look in greater detail at this study's third question regarding the potential links between CSA and psychosis. A further consideration of this chapter will be the contextualisation of these research findings in relation to the social construction of gender, age, mental health and medical discourses. This discussion will also outline some further strengths of this research project, such as the richness of the accounts as well as some of its limitations including the small sample size. I will close this discussion with some final personal reflections regarding my learning process during this project, as well as outlining some directions for possible future research.

4.2. SIGNIFICANCE OF THE RESEARCH

This study has met its goals of exploring the accounts of women who have experienced CSA and psychosis in adulthood. This study has explored across two experiential domains that have hitherto been considered separately in qualitative literature despite convincing quantitative evidence for their integration. The integrated approach adopted here might lend support to clinical work with survivors of psychosis, mental health problems and childhood sexual abuse by considering how mechanisms such as shame, fear, isolation, dissociation and unusual perceptions combine and reinforce each other.

Opportunities to articulate or disclose experiences of CSA to a mental health professional are often not provided in mainstream mental health settings (Read, 2006). This study was an opportunity to discuss with participants in an open and relatively informal way their lived experiences. As such, this study has attempted to give voice to relatively unheard aspects of suffering and survival of CSA and psychosis.

Relatedly, this study has gone some way to outlining women's experiences of CSA that has sought to avoid reconstructing gender stereotypes such as women passively experiencing symptoms (Busfield, 1996). On the contrary, this study has found women to be actively engaged in struggles to understand and cope with the difficulties they have faced. In relation to psychosis, this study has approached 'symptoms' from a largely 'agnostic' position (Harper, 2004), thus seeking to allow the emergence of multiple narratives around the experience of unusual perceptions.

This study's use of IPA's reflective methodology has also been an initial opportunity to track my own development as a trainee clinical psychologist in learning to hear and work with traumatic histories. This raises the question: how do trainees of any psychotherapeutic discipline develop competence in this area? This will be discussed below in clinical implications.

4.3. EXPERIENCES OF CSA

The participants described CSA as horrific multiple traumatic experiences that had terrible consequences during childhood and for their adult lives. They described experiencing painful feelings including: intense shame, self-blame, isolation, confusion, sadness and anger. They described bodily sensations such as being crippled or trapped. They also expressed anger at professional services and family members for perpetrating abuse, colluding with it or allowing the abuse to continue by not listening or being adequately aware of the position they were in as children. They described high levels of detachment from others and from themselves. All of these experiences are found in the wider literature on the effects of sexual abuse on children and adults (Fergusson and Mullen, 1999).

4.4. EXPERIENCES OF PSYCHOSIS

All of the participants described psychosis as confusing and terrifying. However, participants also described a range of ways they used to understand or cope with these unusual and distressing experiences. Romme & Escher (1993, 2000) have pioneered work in uncovering some of the positive aspects of psychotic experiences as well as detailing their negative impacts. Chadwick et al. (2000) have uncovered the importance of appraisals of psychosis in understanding its impact on those that experience it. Appraisals of psychosis were also important in this study, particularly the role fear played in shaping the ‘reality’ or ‘believability’ of an unusual perception, and the existence of negative self perceptions.

The unusual experiences described by the women in this study contained malevolent images of demons, assassins, strangers as well as family members. The voices that they heard during their psychosis were often critical, commanding and shaming. Participants described varying degrees to which they could discern reality at different times in their lives partly as a result of the content of their experiences and partly as a result of the overwhelming fear they frequently experienced alongside.

4.5. LINKS BETWEEN CSA AND MENTAL HEALTH

4.5.1. Confidence

One link between the negative experiences of childhood and subsequent mental health problems was described by participants in terms of a lack of confidence and a fear of taking risks with others or with new projects. Participants felt these may have originated in their childhood experiences of domination, betrayal and disappointment that characterised the abusive environments of the participants as children. Relatedly, Birchwood and Iqbal (1998), and Power and Dalgleish (1997) emphasise that poor self efficacy is an important aspect of feelings of entrapment following psychosis. Participants described how low self confidence may have directly impacted on their childhoods. In adulthood low confidence may have further interacted with mental health including: anxiety, depression, eating disorders and post psychotic appraisals of self efficacy. This may be linked to the participants' descriptions of a sense of separateness from 'normal' life and feeling 'stuck'.

4.5.2. Dissociation & Isolation

One major aspect of the accounts of participants was the extent to which they experienced isolation and dissociation during childhood and how this echoed their experiences of life in adulthood and is consistent with survivor literature (Herman, 1990). Dolan (1991) hypothesised that dissociating should be considered as symptomatic and dysfunctional, but also a useful coping strategy for CSA survivors during periods of stress throughout life. The women in this study described varying degrees of coping by blanking out details of abuse or blanking out other difficult aspects of their day to day lives. It may be useful to consider dissociation as variable, active and passive, and in correspondence to current mental health rather than fixed at a particular level. Lysaker and Lysaker's (2002) narrative structure of self suggested that psychoses represent a breakdown within an individual in the ability of self positions to communicate with one another. Accessing 'self-positions' may be impaired by processes such as dissociation which leave individuals feeling bereft of aspects of themselves, thus deskilling and isolating them further.

4.6. LINKS BETWEEN CSA AND PSYCHOSIS

Overall, the participants had mixed views about whether their unusual experiences were related to their childhood abuse. One participant felt that her psychosis was quite separate from her childhood experiences, particularly as psychotic phenomena never involved family members. On the other hand, she and the other participants expressly stated that their negative experiences as children, including the CSA, had directly impacted on their mental health in adult life. From the perspective of researcher, I felt that a third strand of connections could be discerned in the ways participants described experiences and feelings during and in appraisal of psychotic episodes. These connections will be explored further below.

4.6.1. The body

Participants described links between psychosis and CSA through bodily or felt experiences such as feeling ‘crippled’. Several participants utilised a medical explanation regarding genetic transmission given the existence of other family members also being mentally unwell. Some participants described difficulty in distinguishing between whether their difficulties were organically or bodily based, or were physical manifestations of mental health problems.

4.6.2. Delusional & Hallucinatory Content

This study indicates that aspects of psychosis can be thematically or experientially similar to experiences of CSA. Bannister (1983), Garfield (1995) and Rhodes and Jakes (2004) have provided some evidence to suggest that psychotic content can be meaningfully linked (although causation cannot be directly inferred) to clients’ current and past concerns. In this study some striking commonalities could be discerned in the content of psychosis such as references to paedophilia. The psychosis as described by the participants included images and voices that seemed to resonate with shame. Delusional content often included shame concepts or evoked beliefs about shame. Read et al.

(2006) highlight two possible pathways between CSA and psychotic experience. The first described as the 'traumagenic neurodevelopmental model' outlines that children exposed to repeated trauma show persistent cortisol and dopaminergic irregularities in the hypothalamic-pituitary)-adrenal (HPA) axis. This may confer a heightened sensitivity or vulnerability to further stressors in the environment. The persistently high levels of stress in childhood described by the women in this study may be a reflection of these findings.

The second model is described as 'decontextualised flashbacks'. Here sensory information is re-experienced but impaired source monitoring in patients, due to repressed or dissociated memories, renders the flashback 'decontextualised' and therefore diagnosed as psychosis rather than post traumatic stress disorder (PTSD). In relation to the psychotic content, described by the participants in this study, Read et al.'s (2006) reading of the literature perhaps highlights that externalized source attributions (such as voices or hallucinations) may be forms of unconscious defense, whereby the brain is attempting integration of traumatic experience, without the fully affect laden re-experiencing of the memory of abuse itself.

4.6.3. Beliefs about a Shameful Self

One possible further impact of the psychosis was to exacerbate the negative, uncertain and shame saturated views of self that seemed to characterise participants' self appraisals. Such cognitive self appraisals are commonly found in the CSA survivor literature (Dolan, 1991, Herman, 1990). In this sense, the psychosis 'fitted in' with an already shame saturated self image.

Chadwick et al.'s (2000) findings concerning the beliefs clients hold about their voices, such as the degree to which the voice should be believed or acted upon, relate to this study. In particular, the potency or believability of the voice seemed connected to the malevolence, critical and shaming content and characteristics of the voices or imagery. Highly shaming and accusatory unusual experiences may tap into negative and shame saturated self beliefs in individuals with significant histories of childhood abuse. This would also support Rhodes' and Jakes' (2000, 2004) findings that self evaluations are important aspect of the experiences of psychosis and Campbell and Morrison's (2007) suggestion that psychotic patients may often hold negative self concepts.

One mechanism for this might be related to the 'logic of shame' where the women in this study made conclusions following psychosis that were extremely negative and self-blaming. These findings would seem to point away from Bentall's theoretical position of delusions as a defence against low self esteem (Bentall, 2003) and towards Chadwick, Birchwood and Trower's (1996) concept of 'Bad Me' paranoia in psychosis, although it is recognised here that psychosis may operate differently in different individuals. It may be that survivors of CSA are more likely than other people with psychosis to have 'Bad Me' explanations for unusual experiences. For the women in this study, psychotic phenomena became another path to pre-existing and easily activated negative thoughts or schemas about themselves.

4.6.4. Constructions of CSA & psychosis

The participants' accounts as organised in my writing emphasise interpersonal difficulties and aiming to get better, the role of shame and further links between CSA, mental health and psychosis. This is how I clarified my own thinking about the transcripts as spoken by the participants. However, emphasis should also be placed on broader socio-cultural labels and practices of control, power and gender stereotyping (Crossley 2000). This is not inconsistent with an IPA approach; rather it represents a further layer of interpretation (De Visser and Smith, 2006).

Uncritical use of the term 'psychosis' may serve to obscure individual experiences that may be related to other aspects of mental health or sequelae of CSA. Decontextualised and reifed examples of 'psychotic experience' may act like, or reinforce other labels such as 'personality disorder' or 'schizophrenia' by disabling critical thinking about what constitutes complex and multi-faceted and dialogical experiences (Harper, 2004). Such use of terminology can also ignore power issues such as who defines a given 'delusion' or 'hallucination'. For the women in this study, the labels applied to them, such as 'schizophrenia', did not figure greatly in their attempts at understanding their experiences and may even have impeded their understanding. For them, professionals had applied diagnostic labels having viewed their experiences as irrational and examples of mental illnesses.

4.6.5. Resolving trauma

Sell et al. (2004) argued that recovery in schizophrenia often involved reclaiming oneself as an active social participant distinct from discourses of illness. For the participants in this study this process may have begun by reclaiming their own individual speech acts. In doing so, the women began to apply meaning to their experiences of CSA and psychosis. From the accounts of the women in this study, unusual experiences that had not been authored or meaningfully integrated narratively seemed to remain highly distressing. Irene's example of distancing herself from labels such as 'schizophrenia' highlights the power of reclaiming one's own narrative from the frequent opacity of mental health diagnoses (Wallcraft & Michealson, 2001).

This raises the issue of the kind of terminology used by clinicians when relating to clients. Hirschfield et al. (2005) in their study of young men's experiences of psychosis argued that clinicians should work with multiple explanations of causality of psychosis in order to develop rapport and to aid the integration of psychotic experiences within a healing narrative. This may be analogous to Herringshaw's (1997) finding that recovery in adult survivors of CSA requires a reintegration of traumatic experiences into a new narrative of self. The women in this study had already embarked on such a difficult journey of integration, but often had to do so from an isolated position. Holma and Alkonen (1995) point towards the need for the construction of spaces where individuals who have experienced psychosis can come into contact with multiple narratives regarding causality, allowing clients to co-construct their own accounts of illness and recovery and accessing resources to do so.

The participants described considerable tenacity in striving to recover from and understand their experiences by continuing to engage with the world. This is in contrast to discourses around Schizophrenia which often fail to articulate tangible paths towards recovery (Davidson, 2003). Tooth et al. (2003) found that individuals who had received diagnoses of Schizophrenia often did not think in terms of 'recovery' but rather of 'just getting on' with life. Frequently recovery meant taking responsibility, having structure and organization in their life (Tooth et al., 2003, p76). The women in this study also raise the issue that resolving traumatic experiences of CSA and psychosis can happen by re-engaging with aspects of their lives. The dialectical processes involved in coping and healing were also similar to Bogar and Hulse-Kulacky (2006) conceptions of resiliency. For these women, spirituality, family support and understanding of their experiences formed the backbone to their resolution of trauma experiences.

From another standpoint the issues and concerns for the women in this study were often not qualitatively different from those of other women suffering difficulties in living such as a chronic illness (Wilkinson, 2000). This echoes Macdonald et al. (2005), who found young people who had experienced psychosis were frequently concerned with issues similar to those of their peers.

4.7. STRENGTHS AND LIMITATIONS OF THE STUDY

Strengths

In this study the participants were able to articulate a great deal of their experience, both in terms of their view of events and of themselves. Therefore a strong component of this approach has been in accessing some of the ways in which participants constructed the meanings of their experiences; a stated goal for good IPA studies (Smith, 2003) and qualitative research generally (Elliot et al. 1999, Horsburgh, 2003). This was mainly achieved through the use of the semi-structured interview process, which allowed freedom for the interviewer and interviewee to explore issues in depth. This enabled a unique and idiosyncratic perspective on the experiences of people with CSA and psychosis, which have hitherto only been studied separately or in terms of purported causality.

Limitations

The small number of participants in this study is a weakness in that generalising from this sample to other women, or people with CSA histories and psychosis is problematic. Recruitment was extremely difficult in this study, due to a number of issues.

Considerable time and effort were expended liasing with ward staff and consultant psychiatrists to identify people who might be on the ward waiting for discharge and relatively well. Psychiatric notes and psychiatrists themselves seemed relatively unconcerned with CSA histories and more crisis driven or discharge planning driven. Those who were identified often became less well again, or were discharged from the ward.

The Outpatient psychological service at the hospital received referrals specifically for CBT and psychosis. All of the participants were obtained through this avenue. However, there was not a steady influx of patients who met inclusion criteria or who were willing to undertake the study. Furthermore, certain patients were too ill or disturbed to be asked.

Other outpatient psychologists and psychiatrists did not have such patients, were not working with patients that met inclusion criteria or again they felt it clinically inappropriate to involve/ ask their client to take part. Local day centres felt that although they might have individuals who would meet inclusion criteria, their remit was away from focusing on illness and mental health and more about engagement in activity and community. Local private residential settings were initially enthusiastic, but the specificity of the inclusion criteria meant that there were no potential participants at that time.

One limitation of this current study was the reduction in ‘systematicity’ (Meyrick, 2006) of the project by including an interview with the field supervisor (John Rhodes) present. Ethically, I was concerned regarding the blurred boundary between John and myself as clinicians and researchers. However, I felt it was most important to respect Irene’s wishes and retain her rich and illuminating account by sacrificing a degree of methodological systematicity. This was also in light of the preserved homogeneity of the sample, another important aspect in retaining validity in IPA research. Furthermore, each of the participants had experience of varying degrees of counseling and psychotherapy. This may have decreased the homogeneity of the sample, accounting for differing views of symptoms and therapeutic approaches.

The participants in this study were motivated to take part in research and were highly articulate in their descriptions of events and experiences. This may represent a further limitation to this study in that such individuals do not adequately represent the broader population of individuals who have suffered CSA and psychosis. However, their committed and articulate accounts may give needed insight into the lives of other individuals who have not had opportunities to engage either with research or their own experiences through reflection, therapy or interactions with others.

4.8. CLINICAL IMPLICATIONS

4.8.1. Trauma awareness

This study supports previous work highlighting open discursive therapeutic practices in working with CSA and psychosis survivors (Herman, 1992: McGregor et al. 2006: Larkin & Morrison 2006: Davidson 2003). Thus this study supports the assertion that therapists need to be aware of being able to actively hear and discuss deeply traumatic experiences related to childhood abuse and psychosis. Psychosis might be viewed, following this study, as having at least maintained or exacerbated pre-existing feelings of isolation, distrust, confusion, low self-esteem and physical ill health. Therapists need to be open to incorporating the cognitive, emotional and physical sequelae of trauma histories in their formulations by engaging consistently and meaningfully with clients when they raise them in consultations (McCabe et al., 2002).

4.8.2. The role of dissociation

Exploring the role dissociation plays may be key in understanding and supporting existing coping strategies, including developing awareness of an individual's environmental triggers to dissociation. Dissociation may also play a further role in maintaining the isolation of trauma survivors, making it difficult for others to interact with them, perceiving them as aloof or cold and perpetuating and entrenching their isolation and negative self appraisals (Dolan, 1991). Therefore, helping clients develop their understandings of how others may sometimes perceive them might also be important.

4.8.3. Modelling and validating solutions

Participants described difficulties in addressing experiences of feeling stuck and fearful of setting or achieving new goals. Therapeutic interactions with such clients can seek to model and encourage healthy risk taking, assertiveness and validate clients' own attempts to connect with new people and projects. This study supports the idea that therapists should discuss fear, withdrawal and isolation in a normalising way given traumatic histories of both CSA and psychosis. This might help reduce client hyper-vigilance to ‘pathological’ symptoms yet create a space where clients can begin to identify their own triggers and states of mental ill health. Validation of the client’s considerable personal efforts in dealing with multiple trauma, as well as accessing support from the therapist can also be acknowledged (Rhodes & Jakes 2002). Supporting and identifying clients’ existing skills and coping strategies can also be considered by therapists.

4.8.4. Exploring discourse

Explorations of the impact of power discourses such as gender issues and the illness model are also raised by this study. Gender and power discussions may provide ways to reframe internalised or psychologised aspects of experience that perpetuate, for example, low self esteem or self blame. Explorations of the role of women or children in society and in families may uncover scripts or rules clients use to construct their notions of self. Discussions of diagnostic issues, for example, the ‘sick role’ or medical accounts of causality or prognosis, might also help clients explore the pros and cons of different identity positions as well as how they might be constructed or adopted (Johnstone, 2000: Holma & Alkonen, 1995: Wallcraft & Michealson, 2001). This may help them to accept that they were not responsible for the abuse (Banyard, 2004).

4.8.5. Utilising beliefs

The degree to which participants might draw on ‘negative logic’ in their appraisal of unusual experiences such as seeing a woman running away screaming from one’s self may be crucial in understanding the development of high risk behavioural correlates of psychotic experiences, for example, deciding to kill oneself with a knife or jumping under a train. The ‘logic’ of shame may shape the role of cognitive therapy in working with and challenging self assumptions rather than focusing on psychotic phenomena per se (Rhodes et al. 2002: Larkin & Morrison, 2006). This may also be vital in mitigating against violence directed against the self, which can appear as ‘logical’ to clients during or in appraisal of negative unusual experiences.

4.8.6. Therapist self awareness

A number of clinicians have highlighted the importance of therapists remaining aware of issues such as transference and counter-transference, boundary setting and therapist gender, sexual /theoretical orientation and self care in working with survivors of CSA (Dolan, 1991: Feldman-Summers & Pope, 1994: Little & Hamby, 1996: Jackson & Nuttall, 1997: Nestingen,1995: Simon, 1995). Literature suggests that clients / participants with CSA histories may have different conceptions of personal boundaries e.g. wishing to please or placate therapists (or researchers) at the expense of their own well-being (Dolan, 1991). I have tried to avoid this as much as possible in this study by providing as many opportunities as possible for participants to have their say, define their own terms of reference, or withdraw from the study if they wished. The literature also suggests that therapists should be aware of their own emotional reactions to avoid symbolically or actually re-enacting client victimisation, for example, by boundary violations such as excessive self-disclosure or emotional responses (Mathews & Gerrity, 2002).

In addition, therapists who can develop skills through supervision (Mathews and Gerrity, 2002) in recognizing their own emotional responses (Dolan, 1991) to limited or negative viewpoints, developmental delays and tentative or ambivalent emotions expressed by clients may be better placed to challenge client assumptions regarding hopelessness or negative self appraisals. This may also help trainee therapists to instill a sense of hope in their clients as well as raising possibilities for their own personal growth, health and professional knowledge. Mathews and Gerrity (2002) raise the issue of direct observation and / or review of tapes (or transcripts such as in this study) as methods for increasing trainees' competence in this domain. This would tie in with their call for further process orientated research to flesh out understanding of client / therapist interactions during therapy sessions. From this study I would highlight the role of therapist's / researchers' speech and interactions with clients which could be examined through thematic or structural analysis of therapist questions and responses.

4.9. REFLECTING ON THE ANALYTIC PROCESS

It is important to me to be mindful of the presentation of 'themes' in this project. In particular, in the preceding chapter I have specifically chosen to avoid the presentation of the super-ordinate themes in a neatly contrived manner. I therefore chose not to end on themes relating to making sense and recovery so as to emphasise the ongoing and dialectical nature of recovering and not recovering as described by these participants.

I believe that this study has increased my understanding of IPA and its usefulness regarding the experiences of others with psychosis and abuse histories. Remaining engaged with transcripts and literature helped me to clarify my own thoughts and reactions. This has been an important process particularly given the importance of therapist and therapeutic alliance characteristics in the treatment and politics of psychosis and CSA (McGregor, 2006, Sell, 2004) and in psychological therapy more generally (Norcross, 2002).

I also believe that the process of attending closely to the detail of client speech (a necessary component of qualitative research) has been extremely important in my development as a trainee clinical psychologist. This has raised my awareness of the multiple levels of meaning and interaction that may exist between researcher / therapist and client. The use of language as data, prior to categorization by standardized and potentially reified measures, will hopefully remain an important aspect of my future research and therapeutic endeavours.

4.9.1 Future research

This study has focused on the experiences of four women. Future research could perhaps focus on men's experiences of CSA and psychosis to discern differences and similarities in relation to this study. Busfield (1996) highlights the fact that experiences of CSA may be structurally and psychologically quite different for men. For example, men have been reported to experience greater levels of sexual identity concerns and sexual dysfunction following CSA (Fergusson & Mullen, 1999). Teram et al. (2006) found that gender-based differences exist and are related to perceptions of victimhood, masculinity, homophobia, disclosure of abuse and the expression of vulnerability. Keating et al. (2005) also recognised that male childhood sexual abuse survivors face the same social pressures as other men to live up to the tenets of masculinity but have to navigate dissonance between cultural definitions of manhood and discordant experiences of sexual victimization.

Further qualitative work examining the accounts of therapists' experiences of working with multiple trauma and psychosis histories would be a valuable addition to the literature. Of particular note in this study is the primary focus on participants' accounts of psychosis, but as Harper (2004) points out, psychotic experiences such as delusions are also within an interpersonal and dialogical context. Therefore, this study could be re-examined giving an additional focus to a thematic analysis of the researcher's construction of questions and responses to client speech. This might also highlight in greater detail the sense that I sometimes felt that certain questions were difficult for me to ask, as was listening to particularly graphic or painful accounts from clients. A more systematic and detailed analysis of such therapist speech might uncover useful areas for therapists to consider.

Further research might also wish to explore in more detail ‘bad me’ appraisals of psychosis specifically in relation to CSA. The question raised is: Are survivors of CSA different in their appraisals of psychosis to non abused psychotic patients? Do they believe and act upon negative psychotic experiences more readily? The hypothesis raised here would be that psychotic patients with trauma histories will view voices as more omnipotent and believable due to the negative psychotic experiences ‘fitting in’ with existing highly negative self schemas entrenched by CSA. Such a study could for example employ a quantitative design utilising the beliefs about voices questionnaire (BAVQ: Chadwick et al. 1993) as well as the Child Trauma Questionnaire (Fink et al., 1995) utilised in this study. A further measure of beliefs about self would also be required to ascertain statistical differences in, for example, self esteem.

It is recognised here that this study represents one view of the experiences of the participants. As such this study if undertaken a second time would seek to potentially involve the participants in the co-creation of meaningful questions and areas of discussion. Additionally, the study could focus on returning to and examining further experiential accounts by use of further data gathering, such as diaries, recordings or repeated interviewing. This might reveal more subtle and changing aspects of the phenomena in question.

4.9.2. Conclusion

This study has given a rich account of women's experiences of CSA and psychosis in adulthood. A major new contribution of this study has been to integrate explorations of psychosis and CSA. This study suggests how psychosis and CSA can combine and reinforce each other through intra and interpersonal mechanisms such as shame, fear, isolation, and dissociation. In addition, these may be exacerbated by family interactions and wider societal and medical discourses of gender and illness. Therapists can support client understanding of these interactions and build on existing healthy coping strategies. In doing so, therapists should develop or maintain self-awareness regarding reactions to hearing trauma histories in order to maximize client resolution of CSA and psychosis, protect professional boundaries and maintain their own self care.

5. REFERENCES

Bagley, C., Thurston, W. & Tutty, L. (1996) *Understanding and preventing child sexual abuse - Critical summaries of 500 key studies: Volume 2 - Male victims, adolescents, adult outcomes and offender treatment.* London, Arena Ashgate Publishing.

Bannister, D. (1983) The psychotic disguise. In W. Dryden's (Ed.) *Therapists' Dilemmas.* London: Harper & Row.

Banyard, V.L., Williams, L.M., Siegel, J.A., (2004) Childhood sexual abuse: A gender perspective on context and consequences. *Child Maltreatment, 9,* 3, 223-238.

Bebbington, P.E., Bhugra, D., Brugha, T., Singleton, N., Farrell, M., Jenkins, R., Lewis, G., Meltzer, H. (2004) Psychosis, victimisation and childhood disadvantage: Evidence from the second british national survey of psychiatric morbidity, *The British Journal of Psychiatry*, *185*, 220-226

Beese, A.G., Stratton, P. (2004) Causal attributions in delusional thinking: An investigation using qualitative methods. *British Journal of Clinical Psychology, 43*, 267-283.

Bentall, R.P. Jackson, H.F. & Pilgrim, D. (1988). Abandoning the concept of schizophrenia: Some implications of validity arguments for psychological research into psychotic phenomena. *British Journal of Clinical Psychology, 27*, 156-169.

Bentall, R.P. (2004) *Madness explained*. London: Penguin Books.

Bernstein, D.P, and Fink, L. (1998) *Childhood Trauma Questionnaire: A retrospective Self-Report Manual.* The Psychological Corporation, San Antonio: Harcourt Brace & Company

Bernstein, D. P., Ahluvalia, T., Pogge, D., Handelsman, L. (1997). Validity of the childhood trauma questionnaire in an adolescent psychiatric population. *Journal of the American Academy of Child & Adolescent Psychiatry*, *36*, 3, 340-348.

Berrios, G. (1991) Delusions as 'wrong beliefs' : A conceptual history. *British Journal of Psychiatry, 159*, 14, 6-13.

Birchwood, M., Iqbal, Z. (1998) Depression and suicidal thinking in psychosis: a cognitive approach. In: T. Wykes, N. Tarrier and S. Lewis (Eds.) *Outcome and innovation in psychological treatment for schizophrenia.* Chichester, Wiley.

Busfield, J. (1996) *Men, Women and Madness: Understanding Gender and Mental Disorder.* Macmillan Press Ltd. Basingstoke and London.

Bogar, C.B. & Hulse-Kulacky, D. (2006) Resiliency determinants and resiliency processes among female adult survivors of childhood sexual abuse. *Journal of Counseling & Development, 84*, 3, 318-327.

Boyle, M. (2002) *Schizophrenia: A Scientific Delusion?* 2nd Ed. London, Routledge.

Campbell, M.C., Morrison, A.P. (2007) The subjective experience of paranoia: comparing the experiences of patients with psychosis and individuals with no psychiatric history. Practitioner report. *Clinical Psychology and Psychotherapy, 14*, 63-77.

Cavanagh, M., Read, J., New, B. (2004) Childhood abuse inquiry and response: A New Zealand training programme. *New Zealand Journal of Psychology*, *33*, 137-144.

Chadwick, P.D.J., Birchwood, M.J., Trower, P. (1996) *Cognitive therapy for delusions, voices and paranoia.* Wiley Series in Clinical Psychology. Chichester, Wiley.

Chadwick, P., Sambrooke, S., Rasch, S., Davies, E. (2000) Challenging the omnipotence of voices: Group cognitive behavior therapy for voices. *Behaviour-Research-and-Therapy, 38*, 10, 993-1003.

Chalmers, A.F. (1990) *Science and its fabrication*. University of Minnesota Press.

Chalmers, A.F. (1999) *What is this thing called Science?* Buckingham, Open University Press.

Cloitre, M., Tardiff, K., Marzuk, P., Leon, A., and Portera, L. (2001) Childhood abuse and subsequent sexual assault among female inpatients. *Journal of Traumatic Stress, 9*, 47-60.

Crossley, M.L. (2000) *Introducing narrative psychology: Self, trauma and the construction of meaning.* Buckingham, Open University Press.

Davidson, L. (2003) *Living outside mental illness: Qualitative studies of recovery in schizophrenia.* New York, University Press.

de Visser R & Smith J (2006) Mister in between: a case study of masculine identity and health-related behaviour. *Journal of Health Psychology, 11*, 685-695.

Devitt, M. and Sterelny, K. (1999) Language and Reality. *An Introduction to the philosophy of language*. Bradford Book, MIT Press, Cambridge, Massachusetts.

Dolan, Y.M. (1991) *Resolving Sexual Abuse,* New York & London, W.W. Norton.

Drinna A., & Lavender, T., (2006). Deconstructing delusions: A qualitative study examining the relationship between religious beliefs and religious delusions. *Mental Health, Religion & Culture, 9*, 4, 317-331.

Elliott, R., Fischer, C.T., Rennie, D.L. (1999) Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*, 215-229.

Fergusson, D.M., Mullen, P.E. (1999) Childhood sexual abuse: An evidence based perspective. *Developmental Clinical Psychology and Psychiatry*. London, SAGE Publications.

Fink, L. A., Bernstein, D., Handelsman, L., Foote, J., & Lovejoy, M. (1995). Initial reliability and validity of the childhood trauma interview: A new multidimensional measure of childhood interpersonal trauma. *American Journal of Psychiatry, 152*, 9, 1329-1335.

Forchuk, C., Jewell, J., Tweedell, D., Steinnagel, L. (2003) Reconnecting: The client experience of recovery from psychosis, *Perspectives in Psychiatric Care,* Oct/Dec.

Garfield, D. A. (1995) *Unbearable Affect: A guide to the psychotherapy of psychosis.* New York, Wiley.

Gariquet, D., (2005) Early sexual intercourse. *Health Reports / Statistics Canada*, Canadian Centre for Health Information. *16*, 3, 9-18.

Ghaemi, S.N. (2004) The perils of belief: Delusions re-examined. *Philosophy, Psychiatry and Psychology, 11*, 1, 50-54.

Gillett, G. (1995) Insight, delusion and belief. *Philosophy, Psychiatry and Psychology, 1*, 227-236.

Grossman, F.K., Sorsoli, L., Kia-Keating, M. (2006) A gale force wind: meaning making by male survivors of childhood sexual abuse. *American-Journal-of-Orthopsychiatry, 76*, 4, 434-443

Harper, D.J. (2004) Delusions and discourse: Moving beyond the constraints of the modernist paradigm. *Philosophy, Psychiatry and Psychology, 11*, 1, 55-64.

Harre, R., Gillett, G. (1994) *The discursive mind*. London. Sage.

Herman, J.L. (1992) *Trauma and recovery: From domestic abuse to political terro*r. Londond, Pandora.

Herringshaw, L.R. (1997) Resilience and meaning: The development of concepts of self and world in adult survivors of childhood trauma. *Dissertation-Abstracts-International:-Section-B:-The-Sciences-and-Engineering, 58*,5-B, 2677.

Hirschfield, R., Smith, J., Trower, P., and Griffin, C. (2005) What do psychotic experiences mean for young men? *Psychology and Psychotherapy: Theory, Research and Practice, 78*, 249- 270.

Holma, J., Alkonen, J. (1995) The self-narrative and acute psychosis. *Contemporary Family Therapy*, *17*, 3, 307-316.

Home Office (2006) Official Website (retrieved 10th October 2006:

http://www.homeof fice.gov.uk/documents/children-safer-fr-sex-crime?view=binary

Horsburgh, D. (2003) Evaluation of qualitative research. *Journal of Clinical Nursing*, *12*, 307-312.

Jackson, J, Nuttall, R. (1997) *Child abuse: Effects on clinicians' personal and professional lives.* Thousand Oaks, CA: Sage.

Jacobson, A., Herald, C., (1990) The relevance of childhood sexual abuse to adult psychiatric inpatient care. *Hospital & Community Psychiatry*, *41*, 154-158.

Janssen I, Krabbendam L, Bak M, Hanssen M, Vollebergh W, de Graaf R, van Os J. (2004) Childhood abuse as a risk factor for psychotic experiences. *Acta Psychiatrica Scandinavica, 109*, 38–45.

Jakes, S., Rhodes, J., Issa ,S. (2004) Are the themes of delusional beliefs related to the themes of life-problems and goals? *Journal of Mental Health, 13*, 6, 55-66.

Johnstone, L. (2004) *Users and Abusers of Psychiatry.* 2nd Ed. Hove, New York, Brunner- Routledge.

Jumper, S.A. (1995) A Meta-analysis of the relationship of child sexual abuse to adult psychological adjustment. *Child Abuse and Neglect, 19*, 6, 715-728.

Kia-Keating, M., Grossman, F.K., Sorsoli, L., Epstein, M. (2005) Containing and resisting masculinity: narratives of renegotiation among resilient male survivors of childhood sexual abuse. *Psychology-of-Men-and-Masculinity, 6*, 3, 169-185.

Knight, M.T.D., Wykes, T., Hayward, P. (2003) 'People don't understand': An investigation of stigma in schizophrenia using interpretative phenomenological analysis (IPA). *Journal of Mental Health, 12*, 3, 209-222.

Larkin, W., Morrison, A.T. (2006) (Eds) *Trauma and Psychosis: New Directions for Theory and Therapy.* London, John Wiley & Sons.

Little, L. Hamby, S.L. (1996) Impact of a clinician's sexual abuse history, gender, and theoretical orientation on treatment issues related to childhood sexual abuse. *Professional Psychology: Research and Practice, 27*, 617-625.

Lysaker, P.H., and Lysaker, J.T., (2002) Narrative structure in psychosis: Schizophrenia and disruptions in the dialogical self. *Theory and Psychology, 12*, 2, 207-220.

Mathews, L.L., Gerrity, D.A. (2002) Therapist's use of boundaries in sexual abuse groups: An exploratory study. *Journal for Specialists in Group Work*, *27*, 1, 78-91.

Muenzenmaier, K., Meyer, I., Struening, E., and Ferber, J. (1993) Childhood abuse and neglect among women outpatients with chronic mental illness. *Hospital and Community Psychiatry, 44*, 666-670.

McCabe,R., Burns, T., Priebe, S., (2002) Engagement of patients with psychosis in the consultation: conversation analytic study. *British Medical Journal, 16*; 325, 7373, 1148–1151

McDonald, E., Sauer, K., Howie, L., Albiston, D. (2005) What happens to social relationships in early psychosis? A phenomenological study of young people's experiences. *Journal of Mental Health, 14*, 2, 129-143.

McGregor, K., Read, J., Thomas, D. (2006). Therapy for child sexual abuse: women talk about helpful and unhelpful therapy experiences. *Journal of Child Sexual Abuse*, *15*, 35-59.

Meyrick, J., (2006) What is good qualitative research?: a first step towards a comprehensive approach to judging rigour/quality. *Journal of Health Psychology, 11*, 799-808.

Negrao, C., Bonanno, G., Noll, J.G., Putnam, F.W., Tricket, P.K. (2005) Shame, humiliation, and childhood sexual abuse: Distinct contributions and emotional coherence. *Child Maltreatment, 10*, 4, 350-363.

Nestingen, S.L. (1995) Transforming power: Women who have been exploited by a professional. In J.C. Gonsiorek. (Ed.) *Breach of trust: Sexual exploitation by health care professionals and clergy.* Thousand Oaks, CA: Sage.

Noll, J.G. (2005) Does childhood sexual abuse set in motion a cycle of violence against women? what we know and what we need to learn. *Journal of Interpersonal Violence, 20*, 4, 455-462.

Norcross, J.C. Ed. (2002) *Psychotherapy relationships that work: therapist contributions and responsiveness to patients*. Oxford University Press.

Oliver, S., Clarke-Jones, L., Rees, R., Milne, R., Buchanan, P., Gabbay, J., Gyte, G., Oakley, A., Stein, K. (2004) Involving consumers in research and development agenda setting for the NHS: developing an evidence based approach. *Health Technology Assessment, 8*, 15, 1-148.

O'Neill, N.D. (2006) Childhood Sexual Abuse and its Relationship to Adult Psychopathology. *Unpublished literature review.*

Penn, D.L. Nowlin-Drummond, A. (2001). Politically correct labels and schizophrenia: A rose by any other name? *Schizophrenia Bulletin*, *27*, 197-203.

Perrott, K., Morris,E., Martin, J., Romans, S. (1998) Cognitive coping styles of women sexually abused in childhood: A qualitative study. *Child-Abuse-and-Neglect, 22*, 11, 1135-1149

Phillips, A., Daniluk, J.C., (2004) Beyond "survivor": How childhood sexual abuse informs the identity of adult women at the end of the therapeutic process. *Journal of Counseling & Development, 82*, 2, 177-184.

Power, M. and Dalgleish, T. (1997) *Cognition and emotion: From order to disorder*. Hove, Psychology press.

Rahm, G.B., Renck, B., Ringsberg, K.C. (2006) ‘Disgust, disgust beyond description’ – shame cues to detect shame in disguise in interviews with women who were sexually abused during childhood. *Journal of Psychiatric and Mental Health Nursing*, *13*, 100-109.

Read, J., Agar, K., Argyle, N., Aderhold, V. (2003) Sexual and physical abuse in childhood and adulthood as predictors of hallucinations, delusions and thought disorder. *Psychology & Psychotherapy: Theory, Research and Practice*, *76*, 11-22

Read, J., McGregor, K., Coggan, C., Thomas, D. (2006). 'Mental health services and sexual abuse: The need for staff training'. *Journal of Trauma and Dissociation*, 7, 33-50.

Read, J., van Os, J., Morrison, A.P., Ross, C.A. (2005). Childhood trauma, psychosis and schizophrenia: A literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica, 112*, 330-350.

Read, J., Rudegeair, T., Farelly, S. (2006) The relationship between child abuse and psychosis: Public opinion, evidence, pathways and implications. In Warren Larkin & Anthony P. Morrison (Eds.) *Trauma and Psychosis: New Directions for Theory and Therapy.* London, John Wiley & Sons.

Rhodes, J.E., & Jakes, S (2000) Correspondence between delusions and personal goals: A qualitative analysis. *British Journal of Medical Psychology*, *73*, 2, 211-225.

Rhodes, J.E., & Jakes, S (2002) Using solution-focused therapy during a psychotic crisis: a case study. *Clinical Psychology & Psychotherapy*, *9*, 2, 139-148.

Rhodes, J.E., & Jakes, S (2004) The contribution of metaphor and metonymy to delusions. *Psychology and Psychotherapy: Theory, Research and Practice*, *77*, 1-17.

Romme, M. A. J., & Escher, S. (1993). *Accepting voices.* London: Mind.

Romme, M. A. J., & Escher, S. (2000). *Making sense of voices*. London: Mind

Seedat, S., Stein, M. B., Oosthuizen, P. P., Emsley, R. A., Stein, D. J., (2003) Linking posttraumatic stress disorder and psychosis: A look at epidemiology, phenomenology, and treatment. *Journal of Nervous & Mental Disease, 191*, 10, 675-681.

Schafer, I., Harfst, T., Aderhold, V., Briken, P., Lehman, M., Moritz, S., Read, J., Naber, D. (2006). 'Childhood trauma and dissociation in female patients with schizophrenia spectrum disorders: An exploratory study'. *Journal of Nervous & Mental Disease, 194*, 135-138.

Sell, D.J., Stayner, D.A., Davidson, L. (2004) Recovering the self in Schizophrenia: An integrative review of qualitative studies. *Psychiatric Quarterly*, *75*, 1, 87-97.

Simon, R.I. (1995) The natural history of therapist sexual misconduct: Identification and prevention. *Psychiatric Annals, 25*, 90-94.

Smith, J.A. (1996) Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology. *Psychology & Health, 11*, 261-271.

Smith, J.A. (2003) *Qualitative Psychology: A Practical Guide to Methods. London,* Sage.

Smith, J.A. and Osborn, M. (2003) Interpretative Phenomenological Analysis, in: Jonathan A. Smith, (Ed.) *Qualitative Psychology: A Practical Guide to Methods*. London, Sage.

Smith, J.A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1*, 39-54.

Spataro, J., Mullen, P. E., Burgess, P. M. (2004) Impact of child sexual abuse on mental health: Prospective study in males and females. *British Journal of Psychiatry, 184*, 416 - 421.

Teram, E., Stalker, C., Hovey, A., Schachter, C., Lasiuk, G., (2006) Towards male-centric communication: Sensitizing health professionals to the realities of male childhood sexual abuse survivors. *Issues-in-Mental-Health-Nursing, 27*, 5, 499-517.

Thornhill, H., Clare, L. and May, R. (2004) Escape, enlightenment and endurance. *Anthropology and Medicine, 11*, 2, 181-199.

Tooth, B., Kalyanasundaram, V., Glover, H., Momenzadah, S. (2003) Factors consumers identify as important to recovery from schizophrenia. *Australasian Psychiatry*, *11*, Supplement. 70-77.

Wallcraft, J., Michealson, J. (2001) Developing a survivor discourse to replace the 'psychopathology' of breakdown and crisis, in *This is Madness Too: Critical Perspectives on Mental Health Services,* (Eds.) C. Newnes, G. Holmes, and C. Dunn. Ross-on-Wye: PCCS Books.

Willig, C. (2001) *Introducing Qualitative Research in Psychology: Adventures in theory and methodology.* Buckingham, Open University Press.

Wilkinson, S., (2000) Feminist Research Traditions in Health Psychology: Breast Cancer Research. *Journal of Health Psychology, 3*, 359-372.

Wurr, C. J., & Partridge, I. M. (1996). The prevalence of a history of childhood sexual abuse in an acute adult inpatient population. *Child Abuse & Neglect*, *20*, 867-872.

Appendix A. Participant Information Sheet

The Principal Investigator(s)
Nathan O'Neill, Trainee Clinical Psychologist
University of Hertfordshire
Clinical Psychology Doctorate Programme
Hatfield, College Lane Campus
AL10 9AB

John Rhodes, Clinical Psychologist, Field Supervisor
Psychology Department, St Ann's Hospital
N15 3TH
020 8442 6124

Consent to Participate in a Research Study

The purpose of this form is to provide you with the information that you need to consider in deciding whether to participate in this study

Ref: 03/188 Information Sheet

1. **Study Title: "Childhood Trauma and Difficulties in Adulthood"**

2. **Invitation paragraph:**
You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read this information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you wish to take part.

3. **What is the purpose of this study?**
I am interested in whether people's experiences of childhood trauma affect them later in life and if so in what ways. There is very little research asking service users for their views about their childhood experiences and whether they think they are connected in any way to their current mental health problems. Therefore this study aims to look into whether service users feel there is a connection or not between their early childhood trauma and the mental health problems that developed later in life. We hope that a better understanding of service users' experiences will provide information to help develop better psychological treatments for those who use mental health services. The study will last for approximately 18 months.

4. Why have I been chosen?

I would like to interview around 10 people who have experienced trauma during their childhood and who have had at some time mental health problems. You have been invited to take part in this study because you told us on a questionnaire (that you filled out while in hospital at St Ann's or during the intake interview with Mr Rhodes) that you had experienced trauma when you were growing up and said that you might be interested in taking part in a study about it.

5. Do I Have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw, or not to take part, will not affect the treatment you are offered or the standard of care you receive in any way.

6. What will happen to me if I take part?

If you decide to take part, I will invite you to come for an interview at a time convenient for you. We will meet at St Ann's Hospital and I will explain the study, you can ask any questions and I will ask for your consent to take part. You will be given a copy of the information sheet and a signed consent form to keep. In the interview I will ask you questions about your experiences of childhood trauma, what you see as your current difficulties and how you feel and what you think about them. There are no right or wrong answers since I am only interested in your views. You do not have to answer any questions you do not want to. The interview will take approximately 90 minutes and I will ask you if we can tape record it. You will be interviewed alone unless you want to bring a family member, friend or carer with you. We can stop and take a break at any point during the interview if you wish. You have the right to withdraw your consent at any time during and after the interview without having to give a reason.

7. What are the possible disadvantages and risks of taking part?

Answering questions about your childhood experiences may be distressing as it may bring up painful memories. This is a possible risk. 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.

8. What are the possible benefits of taking part?

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

9. Will my taking part in this study be kept confidential?

If you consent to take part, your medical records may need to be accessed by the researcher to check that the study is being carried out correctly. Your name, however, will not be disclosed outside the hospital. Apart from yourself and the researchers, we would ask your permission to tell your care team that you are taking part. All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you which leaves the hospital/surgery will have your name and address removed so that you cannot be recognised from it. All transcripts of interviews will be made anonymous and only distinguishable by a code. My supervisors who are Dr Pieter Nel (University of Hertfordshire) and Mr John Rhodes (Clinical Psychologist at St Ann's Hospital) will have access to these transcripts in order to help me with the project and data analysis, but they will not be able to identify you. All transcripts, audio-recordings and any notes will be kept in a secure location only accessed by the researchers. The audio-recordings will be destroyed after the thesis viva and the transcripts and paperwork will be destroyed after five years.

10. What will happen to the results of the research study?

The results will be written up as a Doctoral thesis for summertime 2007 and will be published following the submission. If you would like I can give you feedback regarding the overall results of the study either in writing or over the telephone. Direct quotes from interviews will be used in the researcher's thesis and it is likely that they will appear in subsequent publications of the results. However any identifying information (people, places, etc.) will be removed from the quotes so you cannot be identified.

11. Who has reviewed the study?

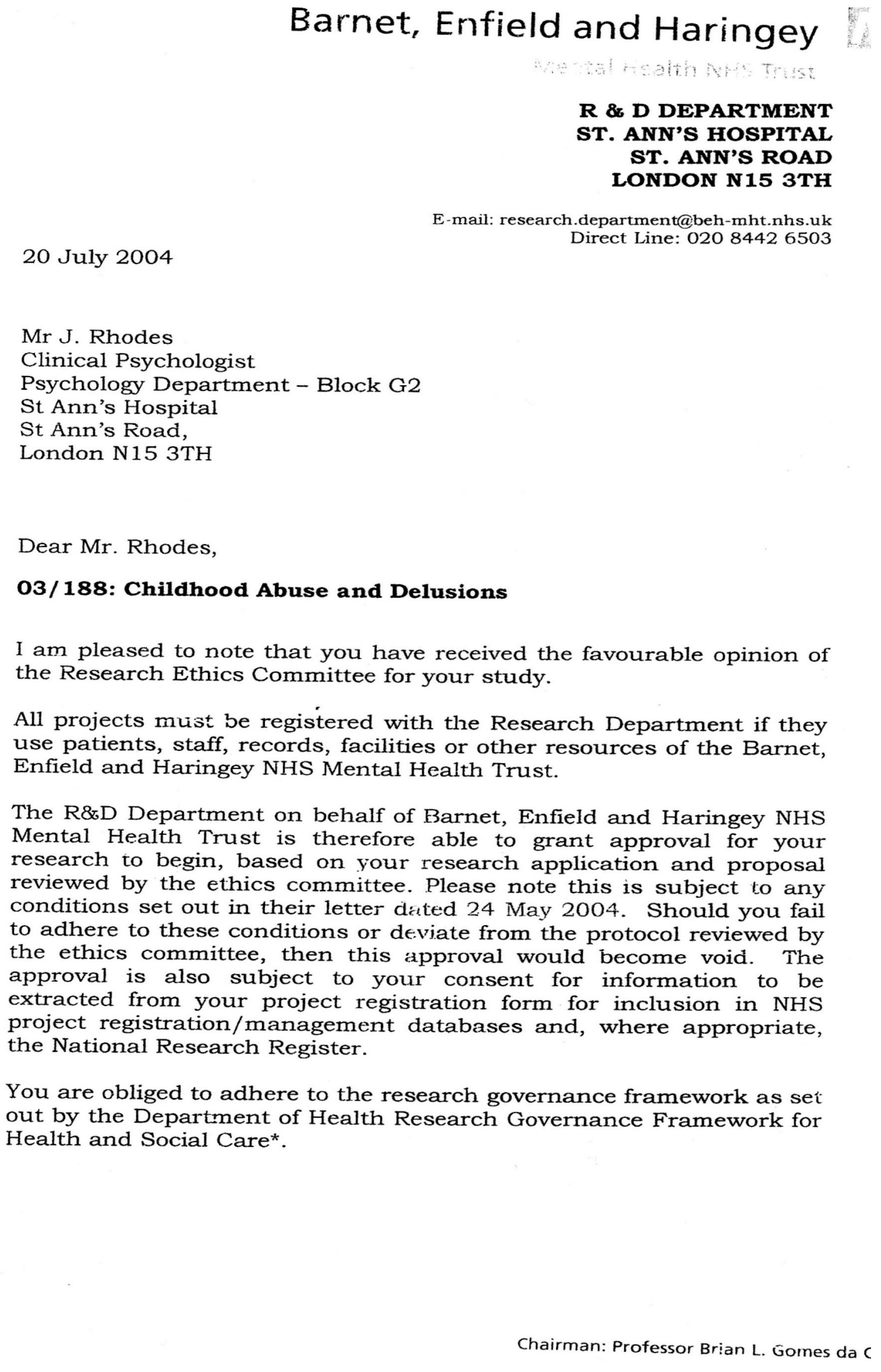
The study has been reviewed by Barnet Enfield and Haringey LREC (Local Research Ethics Committee)

12. Contact for Further Information

For more information please contact: Mr Nathan O'Neill, Trainee Clinical Psychologist by email at University of Hertfordshire:
N.D.O'Neill@herts.ac.uk Or, at St Ann's Hospital on 0208 442 6124

Thank you for taking part in this study.

Appendix B. Research Ethics Committee Approval Documents



Barnet, Enfield and Haringey
Mental Health NHS Trust

R & D DEPARTMENT
ST. ANN'S HOSPITAL
ST. ANN'S ROAD
LONDON N15 3TH

E-mail: research.department@beh-mht.nhs.uk
Direct Line: 020 8442 6503

20 July 2004

Mr J. Rhodes
Clinical Psychologist
Psychology Department – Block G2
St Ann's Hospital
St Ann's Road,
London N15 3TH

Dear Mr. Rhodes,

03/188: Childhood Abuse and Delusions

I am pleased to note that you have received the favourable opinion of the Research Ethics Committee for your study.

All projects must be registered with the Research Department if they use patients, staff, records, facilities or other resources of the Barnet, Enfield and Haringey NHS Mental Health Trust.

The R&D Department on behalf of Barnet, Enfield and Haringey NHS Mental Health Trust is therefore able to grant approval for your research to begin, based on your research application and proposal reviewed by the ethics committee. Please note this is subject to any conditions set out in their letter dated 24 May 2004. Should you fail to adhere to these conditions or deviate from the protocol reviewed by the ethics committee, then this approval would become void. The approval is also subject to your consent for information to be extracted from your project registration form for inclusion in NHS project registration/management databases and, where appropriate, the National Research Register.

You are obliged to adhere to the research governance framework as set out by the Department of Health Research Governance Framework for Health and Social Care*.

Chairman: Professor Brian L. Gomes da C

NHS

Barnet, Enfield & Haringey Local Research Ethics Committee
R&D Office
RNOH NHS Trust
Brockley Hill,
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HA7 4LP.
Tel: 020 8909 5471
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2nd Setpember 2005

Mr. J. Rhodes,
Clinical Psychologist,
Psychology Department – Block G2
St. Ann's Hospital,
St. Ann's Road,
London N15 3TH.

Dear Mr. Rhodes,

03/188 Child Abuse and Delusions

Thank you for recent e-mails notifying the committee of proposed minor amendments to the information sheet and consent form.

The amendment has been considered by the Chair.

The Committee does not consider this to be a "substantial amendment" as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require ethical review by the Committee and may be implemented immediately, provided that it does not affect the management approval for the research given by the R&D Department for the relevant NHS care organisation.

Documents received

The documents received were as follows:

- Information Sheet: Version 1
- Consent form

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

[REC reference number]: 03/188 **Please quote this number on all correspondence**

Yours sincerely,

Alison O'Kane
Administrator

An advisory committee to North Central London Strategic Health Authority

NHS

Barnet, Enfield & Haringey Local Research Ethics Committee
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3rd July 2006

John Rhodes,
Clinical Psychologist,
Barnet Enfield and Haringey Mental Health NHS Trust,
St. Ann's Hospital,
St. Ann's Road,
London N15 3TH.

Dear Mr. Rhodes,

03/188 Childhood Abuse & Delusions

Acting under delegated authority I acknowledge receipt of your letter dated 19th June 2006 informing us of your intention to extend the above study for a further two years.

We have no objection to this proposed extension and would be pleased to receive annual progress reports to keep us up to date.

Yours sincerely,

Alison O'Kane
LREC Administrator

Appendix C. Consent form

Consent to Participate in an Experimental programme involving the Use of Human Participants
Ref: 03/188
Centre Number:
Study Number:
Patient Identification Number for this study:

Version 1 **CONSENT FORM**

July 2005

Title of Project: "Childhood Trauma and Difficulties in Adulthood"

Name of Researcher: Nathan O'Neill **Please initial box**

1. I confirm that I have read and understand the information sheet dated…………(version 1) for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation in voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected ☐

3. I understand that sections of any of my medical notes may be looked at by the researcher where it is relevant to my taking part in research, but understand that strict confidentiality will be maintained. I give permission for this individual to have access to my records ☐

4. I am willing to allow direct quotes from my interview to be used in the researcher's thesis and in the subsequent publications of the results. However, I understand that any identifying information (people, places, etc.) will be removed from the published and thesis quotes so I cannot be identified. ☐

5. I agree to take part in the above study. ☐

………………………………………………………………………………

Name of patient	Date	Signature
………………	……………………..	………………
Name of Person taking consent (if different from researcher)	Date	Signature
……………	…………………	……………

Appendix D. Interview Schedule

Psychosis & Sexual Abuse Interview Schedule (iteration4)

Nathan O'Neill

SignPost 1- OK, I'd like to start by asking about your life at the moment, what you're going through now, and what you have been going through recently-

A. Ok, could you tell me what life is like for you at the moment and for the last few weeks?

B. Can you tell me about any long-term difficulties / symptoms you've been experiencing? When did they start? Could you describe them in detail? What's it like having them?

C. Have you been given a diagnosis of (Schizophrenia, psychosis…..) ? When did you receive that? What is your understanding of the diagnosis?

D. What does that term mean to you? Does it fit with your experiences?

E. Can you describe what life was like before you had these symptoms?

SignPost 2– I'd like to move us on to thinking about your earlier life including childhood experiences. I'm going to ask you a bit about the sexual abuse you suffered when you were younger. I don't want to go into minute details of what happened to you unless you feel it is important talk about them. My interest is in what you think and feel about those experiences. If you need to stop or don't want to carry on just let me know.

A. OK, First of all, just thinking generally about your childhood ; how would you describe your childhood over-all, as you look back on it now?

B. How old were you when the abuse started /stopped? Can you describe the effect or effects the sexual abuse that you experienced had on you when you were younger?

C. Were there any effects that continued after the abuse, into adulthood or to this day? Have any of these changed in any way over time?

SignPost 3- Thinking about the abuse you suffered as a child, and the mental health (& other) difficulties you've suffered more recently (& now) –

A. Do you see any links or connections between the abuse you experienced in childhood and the problems you have now?

B. How have these experiences affected you as a person?

C. What thing/s are important to you in your life at the moment and for the future?

Wind down.

Ok, no more questions from me. How are you feeling after all those questions? Do you need anything? Do you have any questions or things you feel are important that we didn't talk about?

Thanks so much for taking the time to speak with me, all the best.

Appendix E. Sample interview synopsis & member check sheet

Date

Nathan O'Neill, Trainee Clinical Psychologist
University of Hertfordshire
Clinical Psychology Doctorate Programme
Hatfield, College Lane Campus
AL10 9AB

Name

Dear Name,

Re: research on child trauma and mental health

Many thanks for letting me interview you several months ago. I am enclosing some of my thoughts about some of the key things we talked about in the interview. These are just my thoughts and may be quite different from what you think. This is to keep you updated, and to see whether you had any thoughts about the interview.

If you have any thoughts about what I've written, or about the interview more generally please note them down, pop them in the stamped, addressed envelope and post.

I very much appreciate your involvement in this study,

Yours sincerely,

Nathan O'Neill
Trainee Clinical Psychologist.
University of Hertfordshire

Name

Living in fearful isolation
Because of all her abuse, ------ felt afraid almost all the time when she was younger. This lead her to cut herself off from other people to some extent, and from herself too. ----- has also suffered severe mental health problems. She explained how when she was ill she often believed things very easily buying into things until she became deeply unsure of herself.

Making sense of self, others and the world
To this day, it's difficult to work out what the experiences were or what they mean. However, through attending psychotherapy sessions she has built up an awareness of her own thoughts and feelings. She described how it had helped her to make sense of what she thought and said.

Process of relapse and recovery
In the face of all this, ------ has fought for her own justice against the abuser as well as rediscovering her own mental health. Sometimes, ----- worries that she'll get sick again, even with her new understanding, but even so, she feels she has come a long way in healing herself.

My thoughts or reactions to Nathan's interview summary and themes

----

Would you like a copy of any research papers published YES / NO (please circle)

Please put this in the SAE and post, thankyou for your time, Nathan.

Appendix F. (Audit Trail)

Grouped annotations and emerging themes transcript 2
Emerging themes from transcript 2
Clustered themes and superordinate themes 2

[illegible]

① dep – cognitive style
② anxiety
fear
③ psychosis
④ delusional content – Shame / coincidence
⑤ determination
⑥ Trapped – helplessness
⑦ humour
⑧ Caring ⟷ neglect
⑨ fear * Shame
⑩ ~~Ambivalence~~ to abuse / sickness – family +

Annotations Group Transcript 2.

① Depression
② Social Anxiety- agoraphobia
① Everything's a struggle
Medication resistant
① Depression
21 ① Pushing against the struggle all the time
① Apathy- depression
21 ⑤ Determination not to give up.
21 ⑤ Can't give up.
* ① Black cloud hanging over me.
① Depression.
① Black feelings and anhedonia and apathy.
Losing mental stability & deteriorating cusp of another breakdown, something's not right.
① Bleak future
② Social Anxiety with little confidence.
① Complete apathy.
① Executive function impaired.
③ Psychosis is losing reality & breakdown.
③ Hospital x2. six to twelve weeks
③ Went completely mad, hard.- lost
③ Psychosis frightening.
(2-3) Stress built up then key trigger- rape.
Straw that broke the camel's back- sent
③ Explosion of illness – blown.
③ Terrible curse, all negative events'combining, not thinking real
④ Stabbing- penetrating father, perpetrator.
④ Thought I'd killed dad, couldn't get away from the [fear] I'd killed him.
③ Evidence stopped thought but not completely
④ Known to others and shamed with paedophilia
④ Voices telling me to commit suicide but my self belief held me.
④ Command hallucinations
④ Familial voice- shame and shock
⑨ Knowledge not enough to stop believing voices. Fear that it's true and believing, logically concluding suicide because of fear and shame.
⑤ Incredible strength and self belief in the face of fear.
Turned to stone. ⑨
⑨ Known as shamed by everyone and will get worse. Delusions of reference.
* Not just voices, even without voices I could sense it was real.
① Assuming negative attributions of others
① Negative interpretations
④ Visualizing as well as the voices
② Severe fear.
② Turned to stone. Imminent death.
② Stone-fear
② A nightmare
② Reality blurred then when fearful.
③ It felt/it was real.

mum
ambivalent
dad

㉑ Secret.

⑪ perceived solitude / Kept apart
avoided school / abandoned sibs
⑫ damned
⑬ feeling dirty
⑭ no confidence, apathy
no assertiveness.
⑮ Hard on self
'mistakes'
⑯ Anger.
⑰ (Protection)
mum
a good mum
love
of my daughters
my
family +
love –

⑲ re- traumatization
⑱ Assertiveness.
coping
[illegible]
Gene

10 Unwell for longtime
8 I was her carer.
8 Emotional stuff- lots
19 Raped as a teenager.
Pregnancy
21 Kept secret
20 Rebelling, in a crowd rebelling
15 Made a mistake trusting the boy.
21 Went back to my secret
5 But wanted to have a baby

Protection?

21 Didn't tell anyone about pregnancy, then not about rape but / so had to stay in contact with father.
21 Didn't tell anyone, mum maybe guessed, but was silent.
5/21 Let out secret when 'broken down' regrets this.
But couldn't help it.
21 Deep down- a secret- dirtiness deep down, not the same but similar
20 Painful ambivalence
21 Adept at keeping secrets and blanking them out- secret from others, and then self.(denial)
7 Turned to stone (i.e. paralysed by fear)" 9 phrase
Reprimanded by dr.
Laughing at the litany of awful events.
17 Tried to be a good mum.
Protective, loving and educating.
Was coping ok until mum died 21
Big stepping block down. 21
6 Trapped again, just wanted to escape
6 Trapped and like a wife to him- sick expectations
6 Always trying when possible to abuse. Had to be on guard all the time.
Stress accumulates
20 Using booze and drugs
20 Losing control and not as good a mum as should have been.
20 Drinking nightly, still drink now.
Life spiraling out of control
20 Once out of the trap I tasted freedom and wanted to celebrate.
Not sensible.
20 A celebration of freedom
20 Exciting, doing all the wrong things.
20 Drinking and smoking, not there for my daughter- absent, blocking things out and being the teenager
20 Blanking out- not feeling negative emotions with drink- self medicating
8 Began to neglect daughter-guilt
9 Feeling guilty about actions- making mistakes
15 Daughter raped-blames self
4 Trigger to psychosis- rape and age- coincidence
3 Breakdown=psychosis
4 Meaningful link at the time
4 Increased significance of events
4 Extreme homicidal anger
16 Extreme anger triggered voices

Not congruent

④
④ But- logical reason ‘put the knife down’
④ Voices changed
Paedophile theme-
⑩ anger to extreme anxiety- guilt
② Unsure of events
④ Breakdown contains ‘psychosis’ and is a gradual process
② Persistent anxiety
⑮ I make big mistake(s)
Mistrust of own judgement?
⑥ Could change situation- heartache
Police finally involved
⑯ All over, still angry but awareness that high affect not healthy
⑳ Drinking – self medicating
② Noisy thoughts- anxious
㉑ Quiet thoughts- calmer
② Worrying worrying worrying a lot
③ Heavy burden of care for dad
⑩ Ambivalence towards caring for dad
⑥ Feels lumbered by family
⑥ Trapped again
1 ⑥ Trapped with some control
21 Feel ‘not so trapped’
㉒ Genetic link
㉒ Genetic because sister effected also
⑬ Privation of assertiveness- learned helplessness
① Never forget or get over abuse
① Even if genetic the abuse ‘has not helped’ whenever down thoughts turn to abuse
⑱ Self concept limited to not assertive
⑱ Tread all over- like a doormat
㉑ ⑱ BUT feels some assertiveness
⑱ No sense of entitlement
㉑ ① Down now, but not as bad as the past, have more control now.
21 Control over thoughts, feelings and behaviour
21 Acknowledged by others now
21 Not so trapped more control happier
② Social Anxiety
⑬ Forever dirty (inside)
⑧ Enjoys family – caring for others important
Career, opening a new chapter
① Future is bleak. Poverty, drink, an old lady. Hopefully no breakdowns.

6 Suffocated and trapped
By abuser
6 Trapped, gallows
7 Humour
1 Still caring despite abuse
10 Abusing is a sickness- an excuse
11 Happened to all the sisters-ignorant of this
Perceived solitude in abuse.
Every night. Horrible
* A [black] cloud came over him.
9 Frightening horrible experience
8 years
9 Frightened to tell coz of consequences.
9 Scared to tell about abuse, denied it at first.
Wanted dad to go to prison, but not to be killed,
13 Dirty feeling, no confidence, apathy and rebellion.
11 Holding onto a dirty secret always. Avoided school- separate from others- looking after mum.
Little schooling
13 Hard on self- should have worked.
14 Kept separate from others.
11 Strict upbringing
15 Sheltered from life laughing [word play]
15 Sisters left me with him.
15 Still not close.
Other sister has mental health probs.
17 Mum intervened to stop abuse.
17 Felt safer, but still endured milder abuse.
17 Emphasises safe.
17 No police.
16 Ambivalence to mum, she should have done more, but she tried her best.
Angry that I had to go through that unnecessarily.
16 Paedophiles sick born that way [but] I'd kill someone that did it, unlike mum.
5 Stronger than mum
16 Sickeningly soft behaviour rewarding barbarity.
16 Guilty laugh at disliking father.
16 Family disregarded my wishes and minimized impact, they loved him [despite his barbarity]
16 I have ambivalence to him also.- sickness not his fault.
16 Hard to hold the ambivalence.
16 Particularly when he doesn't acknowledge his guilt or the impact.
16 But I don't want to hurt him
17 Mum died and depression started.
17 Trapped [again] no protection
17 Daughter vulnerable
17 Fearful for and protective of daughter
18 Had to leave which was hard. Put foot down wouldn't leave my daughter with him.
18 Left home just after mum died
17 She protected me
8 Not sudden, long process

Transcript 2. Emergent Themes.

Remember- ‘poor me-bad me’ Trower and Chadwick.

+ [illegible]

Setting "the trap."

④ 1. Issues around depression, negative cog. Bias.

④ 2. Anxiety and fear- abuse and delusions

⑤ 3. Psychosis and delusional content- coincidence-trigger, protection-trigger, fear, 'springing the' 'spike' family voices / thoughts, death of dad, paedophile, shot at, shamed, transparent.

② 4. Determination, coping and assertiveness.

② 5. Feeling trapped and helpless, learned helplessness, no confidence or assertiveness. responding to

② 6. Escape, denial, rebelling, celebration, drinking, humour, laughing to relieve tension. ② Trap

CAT ?

① 7. Caring and protection.(KEY THEME) links psychosis to abuse and depression/guilt

① Protection

① 8. Neglect of M. M neglects daughter, linked to protection and psychosis (coincidences).

① 9. Fear and shame- linked to neglect.

③ 10. Solitude- kept apart from others, felt apart from others, abandoned by sisters- still.

③ 12. Feeling dirty, shamed, internalised stigma, keeping the secret.

③ 13. Hard on self- internal locus

③ Living apart.

⑤ 14. Anger – absent, but vengeful in psychosis (out of character).

④ 15. Re-traumatization- abuse, rape, birth, daughter’s rape.

22. Genetic causality vs event causality, not sure.

⑤ 23. Ambivalence to self, mum, dad, family.

① Achieving and failing to protect.

② Living apart.

~~4~~ Responding to feeling trapped.

③ Affective states set the traps

TRANSCRIPT 2 CLUSTERED THEMES

a) Achieving and failing to protect

7. Caring and protection, links psychosis to abuse and depression/guilt
8. Neglect of M. M neglects daughter, linked to protection and psychosis (coincidences).
9. Fear and shame- linked to neglect.
23. Ambivalence to self, mum, dad, family.

b) Living in solitude

10. Solitude- kept apart from others, felt apart from others, abandoned by sisters- still.
12. Feeling dirty, shamed, internalised stigma, keeping the secret.
13. Hard on self- internal locus

c) Negative affect as default position

1. Issues around depression, negative cog. Bias.
2. Anxiety and fear- abuse and delusions

d) Responding to entrapment

4. Determination, coping and assertiveness.
5. Feeling trapped and helpless, learned helplessness, no confidence or assertiveness.
6. Escape, denial, rebelling, celebration, drinking, humour, laughing to relieve tension.
22. Genetic or event based explanations.

e) Psychosis, breakdown and losing the self.

3. Psychosis and delusional content- coincidence-trigger, protection-trigger, fear, family voices / thoughts, death of dad, paedophile, shot at, shamed, transparent.
15. Re-traumatization- abuse, rape, birth, daughter’s rape, psychosis.

List of themes and sub-themes from all participants

A) Living in Fearful Isolation
Living in solitude,
Difficulties with others,
Trapped between withdrawal,
isolation and loneliness, Living in fearful isolation,
Negative views of others,
Social vulnerability.
Feeling stuck in a negative cycle.
Feeling bad as default position,

B) Striving to get better
Attempting to cope with feeling bad,
Finding a new path through life,
Dialectical process of relapse and recovery,
Attempting to make sense of self, others and the world,
Responding to entrapment,
Trying to connect,

C) Relationship with Shame
Negative views of self,
Blurring of boundaries and feelings of confusion,
Psychosis, breakdown and losing the self.
Achievements & Failures of Protection.

Appendix G Interview transcript 2

Initial Reactions	Transcript (2)	Emerging themes
	Transcript 2	
	N- So I guess I'll start by asking how you are now?	
Depression and sleeping probs.	M- Well I'm not too bad, I do suffer from depression. And I sometimes find it hard to go to sleep.	Depression
	N-right	
agoraphobia	M- And em, but apart from that I'm ok. I don't really like going out in crowds. In crowds of people. Apart from that I'm alright.	Social Anxiety-agoraphobia
	N- What…you were saying about depression. What is depression? How would you describe it?	
Everything's a struggle	M- Just you can't seem to feel happy in yourself at all. You're just down all the time and everything is a struggle. That's about it really.	Everything's a struggle
	N- And that, has that been going on for a while for you?	
Medication not effective	M- Yeh, yeh, it's been going on for many years. I'm on antidepressants but they're not really helping to make me feel any different.	Medication resistant
	N-Right, how long do you think that you've felt like that?	
Long-term depression	M- Ehm, it must have been from when I was about 21, 22, to like get depression.	Depression

	N- Right and how old are you now?	
	M- I'm 36 now.	
	N- Right, ok, so quite a few years then.	
	M- Yeh.	
	N- How do you, how do you cope with that? (10)	
Life's a struggle. I have to push myself	M- Eh, I just get up and do what's gotta be done for the day. And that's it really. Sometimes it's a struggle to do daily tasks and that. But I try and get most of it done, push myself really.	Pushing against the struggle all the time
	N- I get, eh, in this interview, I'm probably gonna ask some questions that might sound like I'm pushing you. Questions sort of like, ehm, well what is that? Or em, just I suppose coz em, I'd like to hear as much as possible. So I'm sorry if sometimes it sounds like I'm being deliberately thick about something. Ehm, so for example, I'd be interested to hear what's it (20)like, or what is that process of pushing yourself? Would there be any thoughts that go with that or?	
I feel down all the time, no motivation.	M- Eh, …..not really no, I just feel down and all that and I haven't got no motivation. Em, it's just hard to get daily tasks done. I don't know I can't explain it…	Apathy- depression
	N- Yeh, and when you pu, but there's something also about that you kind of have to push yourself…	
	(30)M- Yeh	

	N- Do you say things to yourself to kind of push yourself?	
I don’t want to just give up	M- Yeh, sort of, I’ve gotta keep going, I’ve gotta keep doing what I’ve got to do. Coz I don’t want to really give up. I don’t want to just give up really.	Determination not to give up.
	N- Yeh,	
I tell myself not to give up	M- I just push myself, keep telling myself I can’t give up.	Can’t give up.
	N- Yeh, keeps you going…	
	M- Yeh.	
	N- Have you had periods when, that’s from 20-21 you were saying, kind of up until now, has it felt like it, or how would you describe it? Has it always been, has it been the same, has it been different at different times in that sort of 15year period?	
Always had a black cloud over me.	M- Yeh, I’ve had a few happy times and that within that time. But I’ve always had that black cloud over me that’s a struggle to be happy.	Black cloud hanging over me.
	N- Yes, is that even going back before 21 do you think?	
Long-term dep.	M- ehm, yeh, even going back before 21, I’d say I was, I’ve had this depression for a long long time. But em, I can’t explain it really.	Depression.
	N- Mm, it’s difficult to…eh, do you have a sense of what does make it difficult to explain? Not having the words or…	
Don’t feel articulate	M- Yeh, not being as articulate as I’d like to be.	

	N- right, yeh……..has anything changed at all in relation to the depression? It sounds like you've had it for a long time. You were saying even before you were 21. Have you had periods where you've not felt so depressed or you've felt…	
Black feelings recently. Everything's a struggle	M- Yeh, I have had periods where I've not felt so depressed. I've felt ok, and excited about the next day. And looking forward to things. But lately, the last few years, I've really just got sort of black feelings, I (10)dunno really. I can't seem to look forward to anything that should be enjoyable. Yeh, it's just a struggle to get out of bed and get moving really, nowadays.	Black feelings and anhedonia and apathy.
	N- Is that….is that…, are there any thoughts that go with that? I mean, what's it like when you do wake up?	
	M- eh,	
	N- like, what was it like waking up today? (20)	
Not mentally stable now. Something's not right.	M- I still felt tired, but I dragged myself out of bed and took the dogs out. I don't feel mentally stable anymore. I don't feel, I feel like my mental health's deteriorating, type thing. I feel like I might have another break down, well not another break down but something's not right with my head nowadays.	Losing mental stability & deteriorating cusp of another breakdown, something's not right.
	N- What's it like, are you sort of thinking about the future there, about what might happen?	
	(30)M- Yeh, yeh. The future looks bleak.	Bleak future

	N- does it	
	M- Yeh.	
	N- Can you say what that bleakness is? I mean what that….	
Hard to socialize and move on. I won't have confidence	M- Eh, it's just myself. I find it hard to socialise or move on with my life or like start up a course or something like that. I don't think I'd ever have the confidence to do that. And em, I dunno really. (10) N…..So we've talked a bit about em, mainly feeling low and depressed…	Social Anxiety with little confidence.
	M- mm	
	N- And you mentioned having no motivation, or very little. Would you say there's no motivation there, or….?	
	M- Yeh, there's no motivation there…	Complete apathy.
	(20)N- really?	
Hard to make plans and carry them out	M- Yeh, It's very hard for me to make plans and carry them out.	Executive function impaired.
	N- Mm. Have you had any experiences maybe a bit different to the depression. Maybe certain thoughts or strange experiences of that sort of stuff?	
Psychosis- lost reality	M- Yeh, I have had an episode of psychosis, like psychotic, psychotic episode. Where I went completely off my head, lost reality and (30)everything.	Psychosis is losing reality & breakdown.

	N- You used the word 'breakdown' earlier. Sort of thinking in a way, or wondering about whether that would happen again. But I don't know, was breakdown, what was the breakdown. Was that the same as the psychosis? M- Yeh, that was the psychosis. N- right, can you say what happened, how long ago was that?	
2xhospital.	(10)M- Well the first, I've had two in the last three years. And the first one was really severe. I had to go in hospital for that. And I was in there for about six weeks, or twelve weeks. And em, N- Was that here at St. Anns?	Hospital x2. six to twelve weeks
Lost my nut, went mad. It was hard.	M- Yeh. I just totally lost my nut. Went completely mad. Yeh, it was *hard*. N- It sounds it. (20)	Went completely mad, hard.- lost
Psychosis really frightening	M- Yeh, it was really frightening. N- Do you have a sense of what had led up to that?	Psychosis frightening.
Stress builds up- daughter raped.	M- I just feel it was a build up of all stresses over my life and that, and then my daughter was raped, N- right, oh gosh…	Stress built up then key trigger- rape.
Sent me off my head	(30)M- Yeh, And then that really did send me off my head really.	Straw that broke the camel's back- sent

	N- oh, that sounds, horrible.	
Horrible, horrible time	M- Yeh, it was a horrible time. Yeh it was a horrible time. But she’s o, she’s doing ok now.	
	N- good	
	M- She’s back at college, and she’s studying nursing now 10mins	
	N- So do you, so there’s a build up you say. A build up of stuff in your life generally, and then a very specific thing that happened.	
Rape blew the top off my head	M- Yeh, yeh. That’s, that’s what blew my top really.	Explosion of illness – blown.
	N- with the stuff, the more general stuff, do you have a sense of what those things were that were kind of building up?	
Rape- I thought it was all coming together, a curse.	M-Eh, just traumatic times in my life. When that happened to my daughter I just thought it was all coming together, and it was all for a reason, and I’d been cursed. It was just awful I was thinking not, you know, not real at all…	Terrible curse, all negative events combining, not thinking real
	N- Mm. Is that what you would call the psychotic bit?	
	M- Yeh.	
	N- Those thoughts.	
	M- Yeh	
	N- Were those, was there lots of those thoughts, or not many or one…or	

	how, what was it like?	
Thought I'd stabbed my dad	M- Yeh, it was quite a lot of different thoughts. Yeh, a lot of different thoughts. I thought I thought I'd killed my father. I thought I'd stabbed him.	Stabbing- penetrating father, perpetrator.
	N- Right….Can you remember why you, or what evidence you had at the time for that thought?	
I couldn't get away from the thought…	(10)M- No, it was just something I thought I'd done. I couldn't get away from this thing that if I went back to my dad's house I'd find him stabbed there. I really did believe I'd gone and done it. That was really hard. And after I saw he was alright, I was so thankful for that.	Thought I'd killed dad, couldn't get away from the [fear] I'd killed him.
	N- Did he, sorry to interrupt, when you saw him, did that stop that thought?	
Evidence stopped thought for a while	M- Yeh for a while. Well, it made me believe he wasn't, you know I hadn't killed him or anything, it stopped that thought for a while… (20) N- right, and for a while…	Evidence stopped thought but not completely
	M- No it stopped that thought.	
	N- Right, And did you have any other ones?	
I thought I was a paedophile and everyone knew, thought I was	M- I thought that I was a paedophile, and that everybody knew what I was. And they thought. No I didn't think I was a paedophile, I thought everybody thought I was. (30) N-right	Known to others and shamed with paedophilia

Prison, suicide. Self belief stopped from doing that.	M- And I thought I was gonna go to prison, and that I should hang myself or put myself under a train or… and the voices were telling me I should do that. But it was me, and my self belief 'but I'm not' that stopped me from doing that.	Voices telling me to commit suicide but my self belief held me.
	N-ok. So there was some voices that were commenting, and saying things.	
	M- Yeh.	
	N- Were the voices there with the dad thought as well? Were they….	
Voices there a lot	M- Yeh, yeh, the voices were there aswell.	Command hallucinations
	N- And they, were you thinking with that one. With the thought about having killed dad. Were the voices sort of saying…., what were the voices saying around that?	
Voices known. Shaming, shock	M- Just, em, I could hear my sister's voice saying '(subject's name) what have you done?! You've killed him!' and, it was them type of voices, people's voices I could hear.	Familial voice- shame and shock
	N- Right. And did you have, was it ever like having a conversation with them, or. Did you, coz you were sort of saying with eh paedophile, there was something different to people thought, you thought people thought, but you didn't, you didn't think that you were.	
	M- Yeh.	
	N- Was that the same with the killing dad one. Did you think that you	

	had or hadn't. Were you able to…	
I knew wasn't peadophile (reality) but felt like everyone thought I was. Really scary. Logic- I'll have to kill myself. Shame.	M- Yeh, I knew I hadn't touched a child or anything like that. I knew in myself. But these people in the, I felt like it was the press and the television were all on me and they all thought I was this paedophile. That was really, really scary as well. I thought, well the voices were saying I'll have to kill myself if that's what I am I'm gonna have to kill myself and that. But I remember standing near the train, I was at Heathrow airport at the time. I'd ended up at Heathrow airport. I don't know where I was going…	Knowledge not enough to stop believing voices. Fear that it's true and believing, logically concluding suicide because of fear and shame.
	N- yeh.	
I know I'm not- resilience	M- I remember waiting for the train. And when I come, I just told myself 'well I'm not, I know I'm not, and I'm gonna prove that I'm not' and that's when I didn't throw myself under the train, but it was really em, really frightening.	Incredible strength and self belief in the face of fear.
	N- I was gonna ask, em, sort of how… M- Yeh N- what it must feel like to have all of that?	
Petrified	M- Yeh, I was really petrified.	Turned to stone.
	N- What was it like then, you were able to sort of say 'no, I'm gonna prove that I'm not'	
	M- mm N- and then, so you didn't…	

Stopped myself but still had to face belief. Just lost real life.	M- Yeh, I didn’t throw myself under the train. But I got on the train and I started really crying. Coz I still believed that everybody thought I was this paedophile and was gonna be on the news. And that my face was gonna be splashed all over the papers. And I could see photographers flashing at me while I was on the train. I really was, I just lost the whole…. Real life and that.	Known as shamed by everyone and will get worse. Delusions of reference.
	N- Do you have a sense of, again, of what gave you or made you… it sounds like the voices were saying it. Em, and then you were thinking that other people thought it as well, is that right? M- Yeh. N- I mean, was it just because the voices were saying it, or was it…	
Not just voices- I could sense it happening/ was real. Didn’t have to listen to voices [to know]	M- No I actually could sense it. I could sense it all happening. Around me aswell. It’s like I could sense it was all real. I didn’t have to hear or listen to the voices. N- yeh M- I felt like this was all real. N- What, what do you mean sense it? What were you picking up on do you think?	Not just voices, even without voices I could sense it was real.
Picking up cues, making assumptions	M- Just people staring at me. People saying things and. Like I was with my sister and I kept thinking she was imagining saying something but she wasn’t saying it.	Assuming negative attributions of others

	N- Yeh, yeh.	
Sensing- making assumptions	M- Em, yeh, I just was sensing, like my brother in law going like that to me, like we were all gonna die and that.	Negative interpretations
	N-yeh	
Visualising, sensing stuff and hearing voices	M- So I was visualizing and sensing things, as well as just hearing stuff.	Visualizing as well as the voices
	N- And you mentioned fear. What sort of, it's a bit arbitrary a question, but in terms of, I mean, how severe do you think that fear was?	
Severe fear	M- Oh, it was really severe.	Severe fear.
	N- was it?	
Fear- man pointing a gun at us	M- Yehh. It was petrifying. At one point I was seeing a man at the window pointing a gun at us all and I threw myself on the floor.	Turned to stone. Imminent death.
	N- You saw someone pointing a gun?	
Turned to stone-petrified	M- yeh. It was really frightening. I was petrified.	Stone-fear
	N- What do you, what do you think now, thinking back on that, those experiences?	
Like a bad dream	M- It just seems like it was just a dream and that. Just a bad dream.	A nightmare
	N-does it	
I know nothing was real	M- Yeh. I know nothing was real. You know, nothing that I thought was	Reality blurred then

It was like a dream	going on was going on at the time. It was all like a dream	when fearful.
	N- And, so, it feels like a dream now.	
	M- mm	
	N- And at the time?...	
But very real at the time	M- it felt very real. It was really real. (10) N- right… You said that there were two times. Was the second time similar or different?	It felt/it was real.
	M- It was not as bad. Nowhere near as severe.	
	N- right	
Suffocated and pushed into being with dad. He was abuser	M- What it was, my dad wanted to go on holiday. He's getting old now, and he wanted to go with me. Coz he always chooses to go on holiday (20) with me. And I feel a bit suffocated and pushed into it. And it was the beginning of this year he wanted to go. And I really didn't want to go, back to Jamaica, where we used to live in his old town and that. It's a lovely place and everything, but I don't really get on with, I do get on with my dad, but I've got problems coz he was the one who sexually abused me.	Suffocated and trapped By abuser
	N- oh right.	
Trapped with him- resignation	M- Yeh. So I feel a bit trapped sort of thing with him, even now (30) [sigh/laugh]	Trapped, gallows Humour

	N- So you're still in contact with him?	
Caring for abuser.	M- Yeh, at the moment he's got the beginning of Alzheimer's. And I'm looking after him, making sure he has something to eat. Coz I'm his only carer at the moment.	Still caring despite abuse
	N-gosh	
Feel sorry for him. Abusing is a sickness- absolution of culpability	M- Yeh, so it's a bit of a struggle. But em, I feel sorry for him mainly. Well all over the years, I felt, well, not when I was a child, but when I (10) grew up, and my mum said that my dad's got this problem, and it wasn't my fault. It was my dad's got this sickness and that.	Abusing is a sickness- an excuse
	N- meaning what, like what was she referring to?	
I didn't know- happened to all of us.	M- Like, sexually abusing us. Coz apparently it happened to my sisters as well, but I didn't know that. I was the youngest. 20mins N- ok. And how many sisters have you got?	Happened to all the sisters-ignorant of this
Separation	(20)M- I've got thr, well I've got four sisters altogether, but two of them are stepsisters and they lived in a separate address. Eh, three of us were together.	
	N- Ok	
I didn't know- I thought I was alone	M- I didn't know that these were getting sexually abused, like my sisters. I thought I was the only one.	Perceived solitude in abuse.
	N- Can I ask a bit about that? That sort of, maybe a bit about that period. (30)What that was like. And I'll just sort of say again, please don't go	

	into details that you don't want to.	
Every night A cloud came over him. Horrible, horrible and frightening	M- yeh. It was just horrible. It was a horrible experience. Every night when I used to go to bed. Coz it only happened at night time. I pretended to just be asleep. But I put things up at the door, or hide in the wardrobe or something, just to make him stop. It was like something, a cloud came over him and he didn't know what he was doing, and I don't know what was going, but it was frightening, and that was horrible, a horrible experience. N- And did it go on for a long time?	Every night. Horrible A [black] cloud came over him. Frightening horrible experience
Years	M- Yeh, it was going on for years, and I couldn't tell anyone. I really wanted to tell my mum but I was frightened of all the consequences and that.	8 years Frightened to tell coz of consequences.
	N- Yeh	
Sister asked about it. Broke down when sharing. I wanted him to go to prison.	M-But yeh, that was going on for some years. I never really spoke up about it, until my sister, my oldest sister, she'd been through it, and she asked me if I was going through it now. At first I denied it. Then she said, but she knows that it's going on. And I started crying and broke down. That's when it all come out. But I thought my dad would go to prison, which I would have agreed for him to go to prison. But my mum said, that he would have got beaten up in prison and killed.	Scared to tell about abuse, denied it at first. Wanted dad to go to prison, but not to be killed,
	N- Right, yeh…	
	M- So we couldn't go that way.	
	N- Is this in Jamaica, or in the UK?	

	M- No this is here.	
	N- In the Uk	
	M- Yeh	
	N- And how old were you when you're sister was asking you?	
	M- I was about 14 then.	
	N- Right	
6-14	M- But it had been going on since I was about six. Or even before that.	
	N- What sort of impact did that have on you back then, at school for example?	
Feel dirty, not confident not interested in learning- a rebel.	M- At school, I used to go to school and feel dirty. And em, I didn't have any, or I didn't feel confident enough. I didn't want to learn anything. I sort of was a little rebel at school really.	Dirty feeling, no confidence, apathy and rebellion.
	N- really?	
Dirty secret all the time. Stayed off school a lot.	M- Yeh, em, I had friends at school, but it was just like I had this dirty secret all the time. And I hardly went to school. I used to stay at home with my mum a lot coz she was quite ill at the time.	Holding onto a dirty secret always. Avoided school- separate from others- looking after mum.
	N- Right	
	M- So, em, I did hardly go to school really, looking back.	Little schooling

	N- Right, and did that impact on you as well at all, not going?	
Should have- worked harder at school- hard on self.	M- Yeh, I should have, I really wish I had stuck my head down at school really. Eh, yeh, it was a terrible terrible time.	Hard on self- should have worked.
	N- Were there other impacts? Sounds like school, in a way kind of there was no room in your head almost for school.	
	M- yeh	
	N- Was there other things, like with friends and other things associated with growing up?	
	M- Mm	
	N- How would you describe your childhood and growing up?	
Not allowed to play out. Sheltered and kept away from everybody.	M- We were always kept, we weren't allowed to play out or, we could have friends in, but we was never really allowed to socialise like other kids. We always had to stay in, or…Mum was really strict, and so was my dad. He didn't like us going out at all, or socialising much. So I feel like I had a sheltered childhood really. Sheltered and kept away from everybody. We kept ourselves to ourselves [sigh, laugh].	Kept separate from others. Strict upbringing Sheltered from life laughing [word play]
	N- Mm, and did the sisters, you were saying you didn't sort of speak about, particularly about the abuse. Did it effect your relationship with your sisters in other ways, or what were your relationships like with each other?	
I'm youngest.	M- They were a bit older than me. I was the youngest one. There was	

	five years between me and the next one.	
	N- Right .	
Not as close to sisters as would like.	M- So I was quite young. And by the time they sort of grew up they'd all left home and had children themselves. So I was the only one left there. But we all get on alright now, well we don't all sort of go shopping together and do things that would have been nice.	Sisters left me with him. Still not close.
	N- Yeh, and you're elder sister that asked you about the abuse, had she left home by then?	
One sister has MH probs.	M- Yeh, she'd left home by then. But she herself suffers from mental health now as well.	Other sister has mental health probs.
	N- Does she?	
Other sister ok	M- Yeh, my other sister, she seems to be un-scathed, she seems to have come through it ok.	
	N- Good, good to hear.	
	N- What was it like, I'm just thinking about, kind of, also coz you mentioned the age of 21, and I'm just in my mind thinking of certain ages. And you had that conversation with your sister. What was life like after that and then going into your early twenties, and leaving school?	
Abuse out in the open, mum protective. Felt really safe with lock on the	M- Yeh, see, once all the abuse had come out into the open, then my mum had a lock put onto my door. So as soon as I go to bed, I could lock myself in. I was happy with that, and I thought, you know, thank god it's all over and he can't get me anymore. And then it would be like	Mum intervened to stop abuse. Felt safer, but still

door.	during the day, he'd like slap my bum or something and that would be awful. Em, yeh, from when I got the lock on the door I felt really safe.	endured milder abuse.
	N- Yeh.	
Repetition of safe.	M- I did feel safe.	Emphasises safe.
	N- Em, that sounded like mum had said, sort of, about not taking it to the police. Is that right, that it didn't go to the police?	
No police involvement.	M- No, it didn't go to the police.	No police.
	N- Em, and at the same time, she sort of helped to put a lock on?	
	M- Yeh	
	N- And helped it to stop?	
	M- Yeh, she did.	
	N- How do you feel about mum and her sort of role?	
Dearly love[d] mum, but felt she should have looked out more, especially with it happening to sisters. Angry that I had to go through it at all. Mum did the best she could tho.	M- I've, I love my mum dearly. And I think thank god for her, in that she did get it all stopped in the finish. But she, I feel she should have known, she should have looked out for me a little bit more, knowing what had happened to my sisters. So I do feel…but she said that she really didn't know, and she thought once it was all out in the open and my dad swore he'd never do it again and everything like that, they just took his word for it. But, yeh, I wish it had come out earlier on, I wouldn't have had to suffer for all them years, knowing that everybody knew what he was doing to the others. I do feel a bit angry about that. Apart from that, no I	Ambivalence to mum, she should have done more, but she tried her best. Angry that I had to go through that unnecessarily.

	do love my mum, and she didn’t agree with what he’d done, and she told him how wrong it was. And em, I think she done the best she could really in that situation.	
	N- And she, you were saying that she used the word ‘sickness’	
	M-Yeh	
	N- To describe those behaviours that he’d done. What’s your sense of that, do you feel like that’s what it is, or?	
Paedophiles born that way. But if it was my husband I’d kill him or take him to prison.	M- Yeh, I think that,eh paedophilia, they’re just born that way. You know, it’s an awful thing to make a child suffer like that. It’s just, yeh I’m more or less on the same grounds as my mum about that. But I think had it been my husband, I probably would have killed him myself or took him to prison or…	Paedophiles sick born that way [but] I’d kill someone that did it, unlike mum.
	N- Right.	
I’d have been stronger.	M- I think I’d have been a bit more stronger.	Stronger than mum
	N- Yeh. Why, why the difference?	
A man should learn it’s very wrong not molleycoddled [like we did, do]	M- I don’t know, I think, I think for a man to do that to a child, he should learn that it’s very wrong, rather than being molleycoddled and told he’d been a naughty boy.	Sickeningly soft behaviour rewarding barbarity.
	N- Yeh.	
I’m stuck looking after him	M- Coz that’s what we’ve done with my dad now. We’ve all molleycoddled him, and I’m sort of stuck with looking after him, type	Guilty laugh at

[with guilt at saying this!]	thing [laughs] I know I shouldn't say it.	disliking father.
	N- Why do you say that, that you shouldn't say it?	
Never wanted to see dad again for years. I just had to put up with him. Not all bad. He has a sickness	M- Coz for years, from when it came out, I wanted my dad just to leave the house. I didn't want to really see him again. But it was my mum and all the family they all loved him, and they wanted him to stay, and the didn't want to split up. So I just had to live with him really. I, he's been good to me as well, he's been a good father as well, like he put me through driving lessons, and got me a car and things like that. So he has had his good points. It's just this sickness that he's got.	Family disregarded my wishes and minimized impact, they loved him [despite his barbarity] I have ambivalence to him also.- sickness not his fault.
	N- Yeh, how, is it difficult to hold those two things in mind about him. That he on the one hand is a good father…	
	M- Yeh…	
	N- ….but on the other hand he has that sickness	
	M- Yeh, it is, it is very hard to hold the two things together.	Hard to hold the ambivalence.
	N- How do you do it?	
Difficult when he thinks relationship fine. 'inside' vs outside. I don't wanna go with him. Don't know how I cope.	M- Yeh, [laughs] I can't explain it. Na I can't explain it really, but it is difficult, especially when he thinks that our relationship's fine and I'm gonna book up and we can go to Jamaica and he thinks everything's fine. But inside I don't really want to go with him, but I don't wanna hurt him and tell him 'no dad, I'm not gonna go' . Yeh, I don't know how I cope with that.	Particularly when he doesn't acknowledge his guilt or the impact. But I don't want to hurt him
	N- Yeh, is, is your mum still around?	

Mum died when M 21	M- No my mum died when I was 21, that's when the depression…	Mum died and depression started.
	N- ah!	
Left alone with dad (again)	M- Coz I was left in the house with him again on my own.	Trapped [again] no protection
	N- Gosh, right I see.	
My daughter.	M And at that time I had a daughter…	Daughter vulnerable
	N- You had a daughter…	
At age 16.	M- Yeh, from when I was 16.	
	N- Ok.	
Worried she'd be at risk. Wouldn't sleep-fear.	M- And I was worried whether he was gonna do it to her. I wouldn't go to sleep, you know I was frightened to go to sleep.	Fearful for and protective of daughter
	N- Yes.	
Watching (vigilant) had to move out. Had to 'put foot down'	M- I was just watching and in the finish I had to move out. And that was hard. Coz he didn't want me to go, and I had to say, put my foot down and tell him that I needed to get out. In the finish I did. I got a place, only a council place, but it was a roof over me head away from him, coz I didn't trust him with my daughter at all. I wouldn't leave him alone in the house with her or anything.	Had to leave which was hard. Put foot down wouldn't leave my daughter with him.
	N- Yeh, yeh, yeh. So she would have been about four, about four/five.	
	M- Yeh, yeh, that's when I left home.	

	N- And so,	
Left home just after death of mum.	M- I left home just after my mum died, coz I couldn’t stay there on my own with him. Especially with my daughter, I just, just couldn’t stay there on my own with him.	Left home just after mum died
	N- So mum had, while she’d been around she had…	
Mum had protected me from abuse.	(10) M- She protected me really while she was around. From what was going on.	She protected me
	N- Was it quite a sudden thing with her dying? was it…	
Long term illness	M- No she was ill for a while. She was, for about three years she was bed-ridden.	Not sudden, long process
	N- Right.	
Mum not well for long time.	(20)M- She was really obese my mum. And she got em, emphysemia [sic] and it turned to pneumonia, and she couldn’t breath, so it was quite a long process.	Unwell for longtime
	N- And who had cared for her through that process?	
Cared for mum through that process whilst looking after nephew and daughter.	M- I was, I was her carer. Yeh, and I was looking after my nephew as well, my sister’s son, and my daughter.	I was her carer.
	N- Was he just a normal kid, growing up that you were looking after?... (30)	
	M- Yeh, David, he was fine, little nephew. He’s 21 now, heh, good boy.	

	N- Wow, so it sounds like a lot of stuff was going on then.	
Lot of emotional stuff.	M- Yeh. It was a lot of emotional stuff.	Emotional stuff- lots
	N- What was the, thinking about having a daughter. What was it like having a daughter at sixteen?	
Raped at 15 years and became pregnant.	M- Yeh, that was another hard thing to go through, coz I was raped as (10) well…	Raped as a teenager.
	N- Right…	
	M- And I fell pregnant…	Pregnancy
	N- So your daughter was, that was from a rape.	
	M- Yeh.	
	(20)N- Goodness me.	
Didn’t tell parents.	M- Yeh, my mum and dad. I didn’t tell them until I was about 8 and a half months pregnant, so it was too late to do anything.	Kept secret
	N- So who had done that to you?	
Older boy did it.	M- That was a boy from just round the corner. He was a couple of years older than me.	
	(30)N- Right.	

I was rebelling.	M- But I used to be in a crowd that I was rebelling at the time. I was about fifteen or sixteen.	Rebelling, in a crowd rebelling
	N- You said that you were quite rebellious at school…	
Made a mistake really. ‘I went back to my secret’ I did want to have a baby [tho]	M- Yeh, and I was in a group of girls, and there was a group of boys just round the corner from here, Suffolk estate. And he was one of them. And em, I went up to his bedroom, which was a mistake really, and that was when it happened. I fell pregnant that first time. I didn’t want to tell anybody, I went back to my secret. Not telling anybody what was going on. And then I was 8 and a half months pregnant before anyone knew. I had my daughter, and I love her, I do love her to bits. Even when I was pregnant I did want to have a baby…	Made a mistake trusting the boy. Went back to my secret But wanted to have a baby
	N- mm, yeh…	
But it was hard. Didn’t tell anyone about rape. Had to stay in contact with father of child.	M- Yeh, but that was hard as well, really hard. And then I didn’t want to tell anyone that I’d been raped. So I didn’t tell anyone I’d actually been raped. Then everyone wanted to know who the father was. So I ended up being, well I’m not friends with him anymore, but I was friends, I didn’t get back with him or anything, but we were like talking like we were friends.	Didn’t tell anyone about pregnancy, then not about rape but / so had to stay in contact with father.
	N- Mm, and did anything happen about that it was a rape.	
Didn’t tell anyone about rape. Mum [maybe] knew but didn’t ask.	M- No, no, I didn’t really tell anybody. I didn’t tell anyone. I think my mum knew deep down but she didn’t really ask me outright. I didn’t tell anyone that I’d been raped.	Didn’t tell anyone, mum maybe guessed, but was silent.
	N- And even now, you still haven’t told many people?	

Told people when I broke down last	M- No, no, I haven't. Only last, when I had my breakdown, that was part of things I was coming out with.	Let out secret when 'broken down' regrets this.
	N- Yeh, ok…	
Regrets telling people.	M- Which I regret, but I couldn't help really coming out with it.	But couldn't help it.
	N- Ok….you used the phrase there, that, with the rape that I think it was like 'I went back to having my secret'	
	M- Yeh…	
	N- Can you explain sort of what you mean by that?	
Carrying on like normal but 'deep down' a feeling that I wanted to tell somebody but couldn't. Similar to prior abuse.	M- Well, it's like carrying on like everything was normal. But deep down I had this f…well a baby and it was a feeling inside of me that I wanted to tell somebody but I couldn't. It wasn't the same sort of thing, but it was, like I had a secret again.	Deep down- a secret- dirtiness deep down, not the same but similar
	N- Yeh, what's that feeling like	
Awful, I wanted to tell someone.	M- It was awful, I wanted to tell somebody. Yeh, I did want to tell someone.	Painful ambivalence
	N- And were you, in your mind sort of well that awful feeling of wanting to tell someone, was that similar or different to having had the history of the abuse…	
I could keep it a secret coz I'm so used to keeping the abuse secret. Blank it out and pretend	M- yeh, it seemed like I could keep it more of a secret, coz I'm so used to keeping that as a secret for so many years. I'd feel like, you know, I just would blank it out and make out everything was normal.	Adept at keeping secrets and blanking them out- secret from

everything's normal.	N- So the depression, going back to where we started, it felt like the depression had been there for an awful long time. And em, a series of incidents, and abuse ongoing for a number of years, em, the rape, em the pregnancy? Giving birth?	others, and then self.(denial)
Traumatic birth	M- Yeh, yeh, that was really traumatic.	
	N- Was it?	
Laughs due to litany of terrible events.	M- Yeh, it was a traumatic time. I was petrified. And I had a terrible birth as well[laughs].	Turned to stone (i.e. paralysed by fear)
	N-Did you?	
Dr telling me off for being so young.	M- There were forceps, aw, it was a terrible time. And the doctor was telling me off for being so young.	Reprimanded by dr.
	N- Right…	
Laughs again at terrible events. Tried to be a good mum.	M- Aw, it was just awful [fuller laugh]. Yeh, that was an awful time. But once I had my daughter, you know. I tried so hard to be a good mum, and make sure she was well cared for and everything.	Laughing at the litany of awful events. Tried to be a good mum.
	N- What is a good mum? What would you say is a good mum?	
Good mum=protective and educate and love them.	M- Someone that protects you. You know, you look out for them and protect them. Try and educate them. That's about it really, just love them.	Protective, loving and educating.
	N- Just sort of going through, maybe up to 21. How do you think you	

	were coping with that? Or how would you have described yourself, or what it was like?	
Coping pretty well up to 21	M- Up to that age, I thought I was coping pretty well with everything and I knew I'd been through a lot but I was sort of coping well with everything. N- Yeh.	Was coping ok until mum died
Mum dying – a big stepping block down.	(10)M- Until like my mum died. That was a big, was a big stepping block down for me really. From then on. N- yeh	Big stepping block down.
Trapped living with dad	M- Coz, from then on I was trapped with just living on my own with my dad and my little girl. And I just wanted to get out of there. N- Did it feel like literally being trapped?	Trapped again, just wanted to escape
Trapped. I was like his wife. Living up to his sick expectations.	M- Yeh. Yeh, it was like being trapped. Coz like he'd want his dinner (20)cooked, I was like his wife sort of thing, and I was living up to his sick expectations of it all. Yeh, and I didn't really like that at all. N- Had he stopped the abuse by then, or was he still…	Trapped and like a wife to him- sick expectations
Father did try to abuse in adulthood once.	M- Well, he had stopped, but one time out in Jamaica, I had a lock on the door then. And my daughter had lost the key one night. And he did come in my room, I was 21 [sigh/laugh] and he did come in my room, and he was stroking me all over and I woke up to find him in there, and I told him to get out. Which he did. But it felt really uncomfortable the next (30)morning. I just wanted to get back home…	Always trying when possible to abuse. Had to be on guard all the time.

	N- yeh…yeh	
	M- And then, so then through your twenties up to the point where you had your first breakdown	
Things were building	M- Yeh, things were building.	Stress accumulates
	N- What was life like in that period in sort of twenties to thirty.	
Started alcohol and cannabis	(10) M-Well, I started drinking alcohol, and smoking Ganja,	Using booze and drugs
	N- Right.	
Losing control of everything. Not as good a mother as I should have been	M- Started losing control of everything really. I wasn't as good a mother as I should have been.	Losing control and not as good a mum as should have been.
	N- What sort of amounts are we talking about here like? What kind of, how much alcohol, was it kind of like a lot….?	
Drinking everynight. Still drink in the evenings.	(20)M- Em, probably about half a bottle of alcohol every night. Mainly be in the evenings, it would have been, it wasn't during the day I used to drink. I used to drink mainly in the evenings. I still do have a little drink in the evenings now.	Drinking nightly, still drink now.
	N- Yeh,	
Life started spiraling out of control	M- But em, yeh, my life started spiralling out of control really, I was…	Life spiraling out of control
	N- What, what do you mean by that? What is, what were the bits that (30)were spiralling out of control?	

Suddenly felt free	M- Dunno, just my. Once I got my own place I felt like freedom and, I just went completely, I dunno I…	Once out of the trap I tasted freedom and wanted to celebrate.
	N- Mm.so….	
	M- I could have been sensible about it….	Not sensible.
	N- Yeh, so you…	
A celebration (to be free)	M- A celebration type of thing.	A celebration of freedom
	N- Yeh, yeh, I mean I have a sense in my head of this sense of being trapped…	
	M- mmm	
	N- You used that word. And then you got out of that trap…	
	M-mm	
	N- And how would you describe getting out of that trap?....	
Exciting [getting out of the trap] but doing the wrong things.	M- It was exciting, I was excited and I was doing all the wrong things sort of thing.	Exciting, doing all the wrong things.
	N- Uhuh	
Drinking and smoking. Should have been there for daughter more. I just wanted to party and be stupid.	M- Drinking enough, and smoking. I should have been there looking after my daughter more. Although I didn't leave her on her own or anything like that. I wish I'd just concentrated on the last few years of bringing her up through her adulthood. But instead I just wanted to party and be	Drinking and smoking, not there for my daughter- absent, blocking things out

	stupid [both laugh]	and being the teenager
	N- So, yeh, I was gonna ask you a bit about … I guess people drink and smoke for lots of reasons. What do you think were the reasons that were leading you to sort of drink and smoke?	
Blanking things out.[a lot]	M- I think just to blank things out. Make things feel happy, in myself and blank out the night times. I used to drink until I could fall asleep with no problems, yeh….dunno really	
	N- And how was it with your daughter and through that period?	
Neglecting daughter. Should have done more.[for daughter]	M- We were alright but…….eh, but I was kind of neglecting her in a, ways. Sort of neglecting her after school, I should have sat down more with her and helped her with homework and things like that.	
	N- Yeh…	
Made a mistake- letting daughter go.	M- And in the finish, she em, my sister over in Harrow said that the schools were all better over in Harrow, coz she was going to go to secondary school. And so my sister suggested that she went to stay over with her. And at the time I said, yeh, that's fine go on. And that was a big mistake really….	
	N- How come?	
Daughter got raped [thus it was a mistake]	M- I let my daughter live with my sister. I wished I'd have kept her with me really, coz that's where she ended up getting raped over at my sister's house.	
	N- ..right	

Daughter’s rape ‘brought it all back’	M- Yeh, that’s what brought it all back to me, and she was the same age as me when it happened to me	
	N- Yeh,	
Big breakdown- psychotic	M- Em, that’s when I had my big breakdown, the first psychotic episode.	
	N- Do you, I mean, how do you kind of make sense of, it sounds like that that was, on the one hand there was lots of things…	
	M- mm	
	N- And then, this… trigger of the psychosis, and you mention a bit about, she was the same age…	
	M- Mmm	
	N- Do you put those things together, do you think…	
Don’t think they link now, but really did at the time.	M- I don’t think they link now, but at the time they seemed really like it was all mapped out, like that was how it was gonna be.	
	N- Right.	
Everything was significant, now just a coincidence	M- It was all significant, and now I know it was just a coincidence really. It was just…	
	N- Yeh, was there something about that coincidence that really impacted on you do you think?	

So angry I wanted to kill. Walked around with a knife.	M- Yeh, I mean, at first I wanted to go out and kill the bloke who'd done it. I couldn't sleep I was so angry. In fact I was walking around late at night with a knife in my hand looking for him, and things like that. N- Walking around the streets?	
So angry I wanted to kill. And the voices kill him, kill him, but I thought I was gonna kill the wrong person.	M- Yeh, I was so angry I really wanted to kill this person. And it was the voices, that's when I started hearing voices of 'kill im, kill im' and I was looking but I couldn't make out which one was him, everyone looked the same sort of thing like, I was gonna kill the wrong person, that's when I had to put the knife down,…yeh, I thought I was gonna kill the wrong one [sigh] N- So that was, building up into the point where you were talking about at the train station and stuff?... M- ..Yeh N- And so you'd had that period of the anger and the.. M- Yeh, N- And you'd had the knife, then you put that down, how did you go from that anger, to that…	
Voices went from kill him to 'your on telly-paedo, computer and internet. Don't know how I thought I'd killed dad	M- I don't know I was sitting on the train, and these voices said, you're on the telly, you're in the newspapers. You and your partner are paedophiles. You've got it all on your computer, on the internet. Oh, it was awful. I don't know how I went from wanting to kill him to thinking that I'd killed my dad and…	

	N- Was this over a period of… I mean, how long was it that you were sort of in that…?	
Whole year was vague, going off my head.	M- Well, my daughter got raped in the January, and I had my breakdown I think in the June or the May or June of that year. But that year was very vague with me going off my head really, me losing the whole plot.	
	N- And had you had, I mean, sort of prior to that as well, your daughter went to live with your sister, were you working, were you in relationships and things…?	
Breaking down over months, not able to look after others.	M- No, I was looking after my niece. My sister was working and she had a baby girl, and I was looking after her. And, em, that was getting too much for me I was, I dunno, I obviously wasn't right then. I was breaking down, sort of thing over a few months.	
	N- yeh, yeh…	
Worried about daughter	M- And I was worried sick about my daughter coz I didn't think my sister was taking that much care of her, and I tried to get her back into a school over this side…	
	N- What was making you think that?	
A really big mistake, letting daughter go.	M- Coz, she would be, she'd be at work, and then she'd get home at eight o'clock and the kids would be on their own from then. And [daughter's name] was 13, 13-14 and she was, I could see she wasn't going to school like she should. So that was a really big worry. I made a really big mistake there.	
	N- Right…	

	M- When I tried to get her back into the schools back down here, there was no room in any of the schools. So that was a bit of, that was heartache as well.	
	N- Did anything happen about your daughter. The rape of your daughter, were the police involved?...	
	M- Yeh, the police were involved with that one… N-Ok	
This time went to the police.	M- And it went to court, and he got off on the rape, but he got done for underage, coz she was underage…	
	N- Right, I see	
Still think back with anger. Could still kill. But calmed self down as not good for self.	M- Yeh, that's all over now, but, I still think back with anger. I still feel I could still kill him, but I've had to calm meself down, coz I know it ain't no good for me.	
	N- Yeh, and how do you do that? What helps you to calm yourself down?	
By drinking	M- Em, dunno, probably a drink really. To have a drink, and just try and chill out. 50mins	
	N- Yeh, is there a cha..what, again, maybe it sounds like a silly question but I'm just wondering what the difference is between feeling chilled out and not? Is it feelings, is it different thoughts?...	

Noisy thoughts, can't concentrate vs. quieter thoughts.	M-Yeh, the thoughts are much quieter in my head. Sometimes they're noisy thoughts and I can't concentrate, and I can't think. I'm just anxious about something or worrying about something. Or there's times where my mind's just at peace really where I can sit and relax and not worry too much about things.	
	N- So, noisy thoughts. Like there's lots of thoughts or the thoughts are really…?	
Worrying a lot. Worrying , dad has alzheimer's.keeps going missing.	(10)M- Just worrying. Like worrying thoughts. I worry about my dad a lot now coz he's living on his own. And he's got this Alzheimer's, the beginning of that. So I do worry about him a lot now, coz he keeps going missing and things, so he's becoming a big worry in my mind now.	
	N- So do you go over there to his to look after him quite frequently?	
Look after him every day.	M- Yeh, everyday. I'm up there everyday giving him something to eat. Make sure he eats. Coz he won't, he'll just forget to eat. Make sure he has his drinks. And I get him these drinks from the doctor as well, his (20)ensure+ that build him up. Yeh, just making sure he keeps eating and drinking alright. So I'm up there everyday doing that.	
	N- And what does that feel like?	
Hard slog, wish I didn't have to do it, looking after him, no one helps.	M- A hard slog really. I wish I didn't have to do it. But seeing as I'm not working, and I do feel really sorry for my dad as well so…I don't mind doing it, but sometimes it's… I wish someone else would give me a hand sort of thing, like my sisters or….	
	(30)N- Is that because…or why don't they?	

	M- Well they're both working. I'm the only one that's not working so it's just put on my shoulders really. They've got families	
	N-And does it feel, how would you describe how it feels….?	
Trapped again.	M- I feel trapped again.	
	N- Do you?	
Trapped but with more control.	M- Yeh. I feel all a bit trapped again. But I feel I'm in control this time more.	
	N- You do?	
	M- Yeh. Although like, if it gets too much I'll get him meals on wheels or something like that, or…	
	N- Ok.	
	M- Yeh, I don't feel so trapped into it this time.	
	N- So the control is helpful?	
	M- Yeh.	
	N- Like having a sense of control. Like, something about that you could stop and get someone else involved to help.	
	M-Mmm, yeh. Yeh, that's more helpful.	
	N- Thinking about all of the stuff that happened to you when you were	

	younger. M-Mm N- And the mental health difficulties you've faced more recently, particularly the sort of the breakdowns… M-Mm (10)N- Do you think that they are linked, not linked?	
Got a feeling they're linked or it's genetic.	M- I've got a feeling they've got a link. It's either that or it's genetic. But I should think, I think there's a link. And my partner think's there's a link between that as well. N-Mm, so what would be, one thing would be gen…	
Sister had psychosis	M-Well my sister's got the same sort of illness. She's had psychotic episodes and that. She's quite worse than me. (20) N- Is she?	
Speaks like a little girl	M- Yeh, if you speak to her, she speaks like a little girl and she's 42years old… N- Right. M- And, yeh, I've got a feeling it could, it has had an effect on her. And it has had an effect on me aswell. (30) N- Do you have a sense of how that might have happened, or what it	

	did?...	
Maybe the assertivness. Living with something you can't change, forced to live with it.	M- I think it might be the assertiveness. Like living with something that you can't make, you know you can't change. You're forced to live in that circumstance where you can't change it or…	
	N-Uhuh	
Never forget or get over it. Or maybe its genetic.	M- I think it's that. And then you grow up, it's something you never forget about, or never get over. I don't really know, I couldn't answer (10)you that. It could be a genetic thing I really don't know.	
	N- Genetic in the sense of…I mean, what would you mean by genetic?	
Also have a cousin [unwell] [either way] the abuse has not helped. Whenever down its always about that. Suicidal always about that.	M- Well, I've got a cousin who's not all there either. He lives in Jamaica and he's had psychotic episodes. And like my sister as well and me. So it could be a genetic thing. But I don't think the abuse has ever helped, coz when I ever do have a breakdown or when I really get down in thoughts, it's always about that. It makes me get down. Like if I get suicidal it's always thoughts about that… (20)	
	N- Yeh, can you describe some of those thoughts? What might, what thoughts might come in at that point?	
Thoughts about what he did.	M- Just the things he used to do and that. Yeh.	
	N- So in a way kind of visualising…?	
Visualizing.	M- Yeh, what used to go on. It makes me feel sad and	
	(30)N- Yeh, and there's something about, assertiveness? You were saying. What is, how would, can you say more about that? What is it	

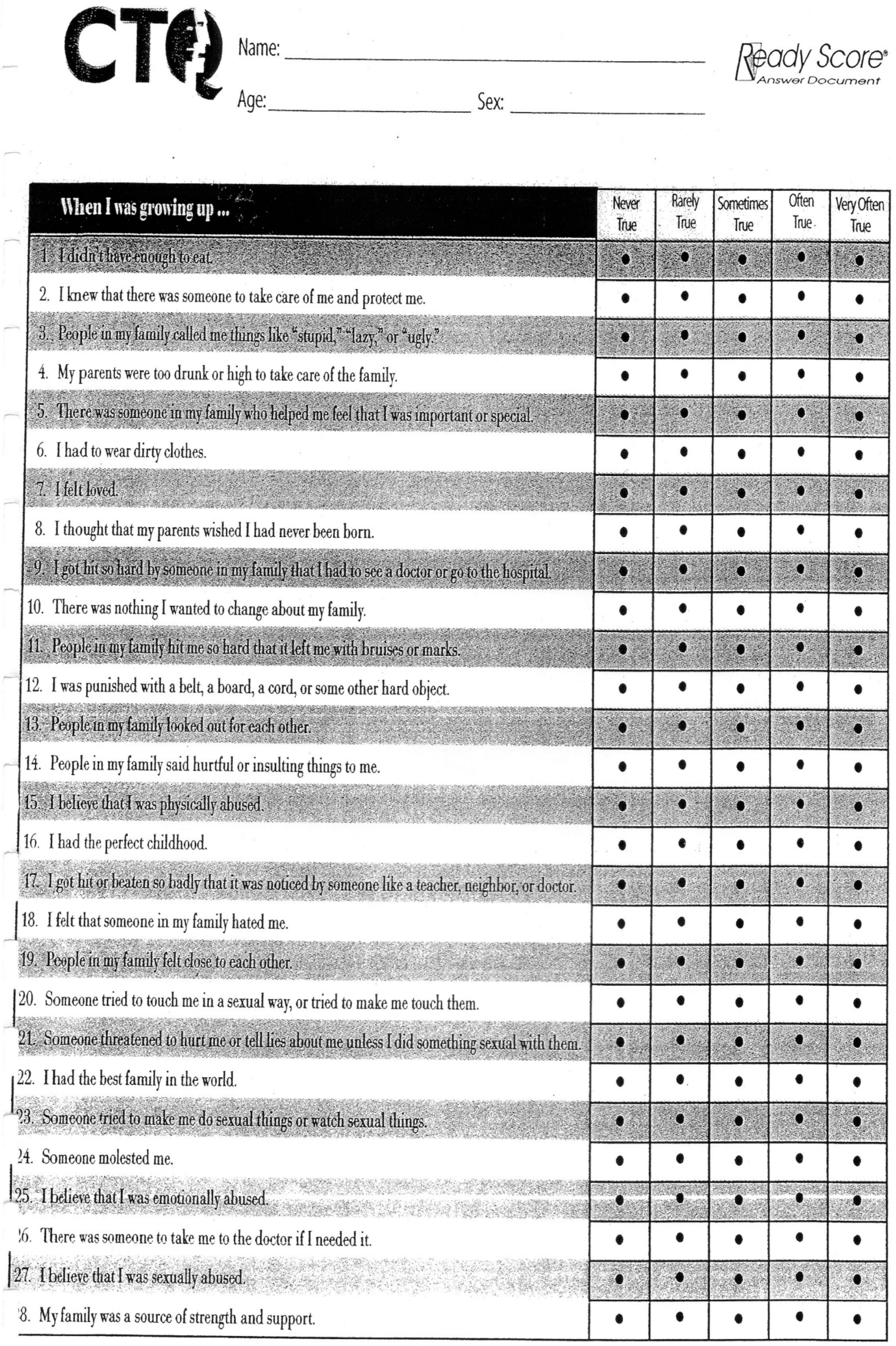
	about assertiveness or what's your relationship to assertiveness?	
I'm not assertive	M- Yeh, I'm not very assertive myself and em…	
	N- Right, what would you say being assertive is?	
Speaking up for their own feelings, I don't do that. I get 'tread all over'	M- Well, someone speaking up for their own feelings. And not letting everyone tread all over them really. Yeh.	
	(10)N- And you feel that you don't have that, or?	
Little bit more assertiveness lately.	M- Yeh, I don't feel I have assertiveness. Well I do feel I have it a little bit lately…	
	N-Yeh?	
Before felt I should never speak up about feelings.	M- Yeh. But before I never felt like I should speak up for myself or say how I was feeling.	
	N- Yeh. What's happened lately that? You sound like you're a bit closer (20)to assertiveness when you said that.	
Feel more in control now. Getting my own life back a bit.	M- Yeh, I'm feeling more in control of myself. Looking over the years now, I feel more in control. But I still feel pretty down and depressed, but I do feel more in control nowadays than I did years ago. Feel like I'm getting my own life back a little bit.	
	N- Right, and is that control about control over how you feel, or control over what you do, control over what you think? Is it any of those? (30)	
Control over feeling, doing and	M- Yeh. It's all three of those…	

thinking		
	N- All three?	
	M- Yeh.	
	N- And there's something about assertiveness there, linked to that control?	
People listen to me more now.	M- Yeh. I feel like I'm, people listen to me a little bit more now.	
	N-Is that important?	
Able to state my limits more now. Not put upon so much, not at their 'beck and call'. Not so trapped, little bit more happier.	M- Eh, It is, it is a little bit important, coz before everyone would put things, coz I'm not working if anyone's got something they needed doing like a prescription to pick up or waiting for the gas man, they'd always ask me and I'd be at there beck and call really. But now, I've started sticking up for myself saying 'no sorry I can't do that' or…I feel more in control of meself. A little bit more happier, not feeling so trapped into things.	
	N- Yeh. Yeh. I suppose we are coming to the end of the interview. Just a few more minutes maybe. Just a couple of things and maybe end. One was in a way, do you think that, all of the experiences that you've had, have they impacted on how or the way you see yourself, or the way you think about yourself?	
	M- Yeh, I think it has had an effect.	
	N- What kind of thing do you think?	
Yeh, abuse had an effect.	M- Well, I get nervous around people. I'm shy, I still feel dirty, no matter	

Nervous around people. Still shy, still feel dirty, no matter what, the odd one out.	how many times I have a bath and that. I still feel that dirty feeling, yeh. I do feel like the odd one out at times.	
	N- Uhuh, at times not the odd one out?	
	M- No, most of the time I feel the odd one out.	
Odd one out most of the time.	N-Most of the time, do you? Yeh. And my other question was just about what sort of things are really important to you at the moment? And thinking about the future what would be important for you? Just generally.	
Important to live more happily	M- Eh, just to live life more happily now. And look forward, coz I've got a grandson now, heheh…	
	N- Congratulations!	
	M- Aw thanks, he's three already, he's three today…	
	N- Oh wow! Goodness, lovely.	
Enjoying my grandson and get a little career going.	M- Yeh, just enjoying him like growing up now. Eh, I'd like to get myself a little career going. After all these years I haven't done anything.	
	N-Uhuh, what sort of thing?	
Anything really, cleaning.	M- Eh, don't know really, driving job, something I've not gotta, not too sure really. Anything really, cleaning. Yeh, anything really.	
	N- And we talked a little bit about how you saw the future, ehm, earlier on today, and you were just talking a bit about maybe worrying a	

Negative view of future. Live in poverty, always a drinker, hopefully no more breakdowns.	little bit about it… M- Yeh, N- So generally thinking, how do you sort of see the future. How life's gonna be for you? M- Oh, I think I'm gonna end up living in poverty. I'll always have a problem with the bottle I think. I like my drink. I hope I don't have no (10)more breakdowns. Yeh, I don't really know really how I see myself in the future. Just an old lady [laugh/sigh]. N- Ok, thank you very much. I'm gonna stop there. I just like to ask people if there are any other questions that they have I can switch off at this point. M- Yeh, no, I'm… N- Eh, were there any thoughts that came up in the interview for you? (20)Any questions that you had? M- No, no. nothing. It's been nice talking it trhough. It's been good to talk it out. N- Good. I'll switch this off. (30) Time(1.02.25.)	

Appendix I: The Child Trauma Questionnaire



CTQ

Name: ____________________

Age: ____________ Sex: ____________

Ready Score®
Answer Document

When I was growing up ...	Never True	Rarely True	Sometimes True	Often True	Very Often True
1. I didn't have enough to eat.	●	●	●	●	●
2. I knew that there was someone to take care of me and protect me.	●	●	●	●	●
3. People in my family called me things like "stupid," "lazy," or "ugly."	●	●	●	●	●
4. My parents were too drunk or high to take care of the family.	●	●	●	●	●
5. There was someone in my family who helped me feel that I was important or special.	●	●	●	●	●
6. I had to wear dirty clothes.	●	●	●	●	●
7. I felt loved.	●	●	●	●	●
8. I thought that my parents wished I had never been born.	●	●	●	●	●
9. I got hit so hard by someone in my family that I had to see a doctor or go to the hospital.	●	●	●	●	●
10. There was nothing I wanted to change about my family.	●	●	●	●	●
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.	●	●	●	●	●
13. People in my family looked out for each other.	●	●	●	●	●
14. People in my family said hurtful or insulting things to me.	●	●	●	●	●
15. I believe that I was physically abused.	●	●	●	●	●
16. I had the perfect childhood.	●	●	●	●	●
17. I got hit or beaten so badly that it was noticed by someone like a teacher, neighbor, or doctor.	●	●	●	●	●
18. I felt that someone in my family hated me.	●	●	●	●	●
19. People in my family felt close to each other.	●	●	●	●	●
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.	●	●	●	●	●
22. I had the best family in the world.	●	●	●	●	●
23. Someone tried to make me do sexual things or watch sexual things.	●	●	●	●	●
24. Someone molested me.	●	●	●	●	●
25. I believe that I was emotionally abused.	●	●	●	●	●
26. There was someone to take me to the doctor if I needed it.	●	●	●	●	●
27. I believe that I was sexually abused.	●	●	●	●	●
28. My family was a source of strength and support.	●	●	●	●	●

CTQ

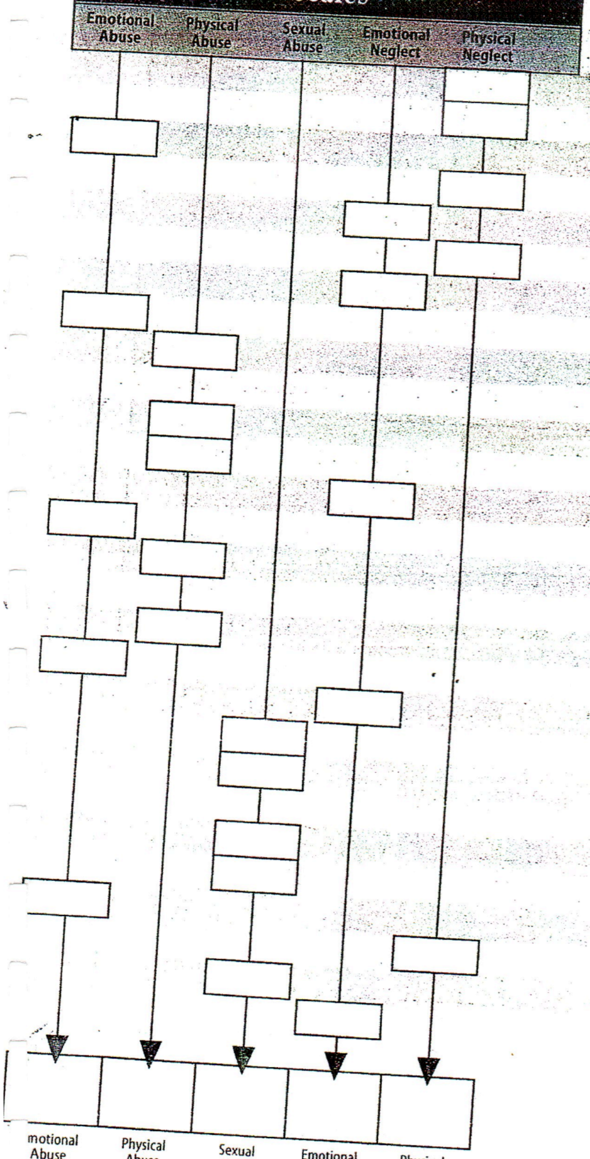
Name: ____________________

Age: ______________ Sex: ______________

Ready Score® Answer Document

Scales

Emotional Abuse	Physical Abuse	Sexual Abuse	Emotional Neglect	Physical Neglect



motional Abuse Scale Total Score (5–25)	Physical Abuse Scale Total Score (5–25)	Sexual Abuse Scale Total Score (5–25)	Emotional Neglect Scale Total Score (5–25)	Physical Neglect Scale Total Score (5–25)

________ ________ ________ ________ ________ Classification

______% ______% ______% ______% ______% Percentile Rank (Reference Group: ____________________)

Item Response Scores

	Never True	Rarely True	Sometimes True	Often True	Very Often True	M/
1.	1	2	3	4	5	
2.	5	4	3	2	1	
3.	1	2	3	4	5	
4.	1	2	3	4	5	
5.	5	4	3	2	1	
6.	1	2	3	4	5	
7.	5	4	3	2	1	
8.	1	2	3	4	5	
9.	1	2	3	4	5	
10.	1	2	3	4	5	0 1
11.	1	2	3	4	5	
12.	1	2	3	4	5	
13.	5	4	3	2	1	
14.	1	2	3	4	5	
15.	1	2	3	4	5	
16.	1	2	3	4	5	0 1
17.	1	2	3	4	5	
18.	1	2	3	4	5	
19.	5	4	3	2	1	
20.	1	2	3	4	5	
21.	1	2	3	4	5	
22.	1	2	3	4	5	0 1
23.	1	2	3	4	5	
24.	1	2	3	4	5	
25.	1	2	3	4	5	
26.	5	4	3	2	1	
27.	1	2	3	4	5	
28.	5	4	3	2	1	

Minimization/ Denial Scale Total Score (0–3)

4

JOURNAL READY ARTICLE FOR PROPOSED SUBMISSION TO THE JOURNAL OF MENTAL HEALTH

WOMEN'S EXPERIENCES OF CHILDHOOD SEXUAL ABUSE AND PSYCHOSIS IN ADULTHOOD: A QUALITATIVE STUDY

5020 words

WOMEN'S EXPERIENCES OF CHILDHOOD SEXUAL ABUSE AND PSYCHOSIS IN ADULTHOOD: A QUALITATIVE STUDY

Nathan O'Neill, John Rhodes & Pieter W Nel

Abstract.

Objective: To date there have been no known qualitative studies of adults who have experienced childhood sexual abuse (CSA) followed by psychotic experiences later in life. This study aimed to explore how a sample of four women make sense of their childhood experiences of sexual abuse and their psychotic experiences later in life.

Methodology: Data was gathered through semi-structured interviews with four women. The data was analysed using Interpretative Phenomenological Analysis (IPA) in order to develop a detailed understanding of the women's search for meaning in their own lives.

Results: Three major themes emerged from the analysis of the women's accounts: *'Interpersonal difficulties,'* *'Striving to Get Better'* and *'Links between CSA, mental health and psychosis.*

Conclusions: The women's accounts highlight the ongoing difficulty of living with psychosis and CSA. Clinical implications include: supporting integrated understandings of psychosis and CSA from personal, interpersonal and discourse perspectives.

Introduction

There is growing quantitative evidence that childhood sexual abuse (CSA) is a causal factor in the development of psychosis in adulthood (Jaansen, 2004: Larkin & Morrison, 2006; Read et al. 2005). Qualitative studies of psychosis have examined delusions, recovery and treatment approaches to hallucinations (Davidson, 2003; Knight, 2003: Rhodes & Jakes, 2000, 2004). Qualitative studies of CSA have emphasized the importance of shame, resiliency and recovery (Bogar & Hulse-Kulacky, 2006: Grossman et al., 2006: Herringshaw, 1997: Negrao et al., 2005: Perrot et al. 1998; Phillips & Daniluk, 2004: Rahm et al., 2006).

Despite the above literature there remains a paucity of qualitative studies examining the lived experiences of people with both psychosis and CSA histories. This study therefore asked participants about 1) Their experiences of psychosis in adulthood 2) Their experiences of CSA, and 3) Whether they felt the experiences were linked in any way.

Sample characteristics

The four participants were female with an age range of 32-48. All participants had experienced CSA ascertained by the Child Trauma Questionnaire (CTQ) (Fink et al., 1995). All participants had experienced psychosis as verified by psychiatric clinical notes.

Procedure

Participants were contacted via a local Clinical Psychology Service having been asked if they would be willing to participate while attending an outpatient assessment. If, yes, participants were later phoned to give them more study information and to check if they were still willing to participate. If, yes, interviews were arranged at an outpatient setting familiar to them. Participants were informed they could withdraw at any point without affecting their treatment.

Semi-structured interviews (Smith & Osborn, 2003; Willig, 2001) were used to ask participants about the emotional and psychological effects (not the concrete or specific details) of their CSA as well as their psychosis in adulthood. Interviews lasted approximately 60 to 90 minutes and were recorded and later transcribed by the interviewer. Participants were offered debrief and any psychological follow-up should the interview be upsetting. None of the participants reported any ill effects from the interviews.

Analytic Process

All names, places and other identifying information were altered to preserve anonymity. The transcripts were then analysed using interpretative phenomenological analysis (IPA) (Smith & Osborn, 2003). IPA is an 'idiographic' methodology, examining in detail an individual case, then moving onto another, building up a rich, novel, valid and detailed understanding of a small sample.

The first transcript was read a number of times. At each reading the transcript was annotated, moving from initial thoughts and ideas raised by the text to more detailed, interpretative and structured coding. Interpretative comments and researcher thoughts were re-checked with the text, allowing the emergence of specific themes for the first participant. This process was repeated for the remaining three participants.

Once all four transcripts had a list of themes they were then integrated and organised into headings and sub headings (see Table 1). Throughout this process referral back to each of the individual texts kept interpretations close to the verbatim data (Smith et al., 2003; Smith, 2004). Themes were kept in the analysis according to prevalence within and across the four transcripts or if comprised by novel data (Knight, et al., 2003: Smith & Osborne, 2003). Themes were also checked by second authors to increase validity (Smith, 2003)

Interpersonal difficulties	**Striving to get better**	**Links Between CSA, Mental Health & Psychosis**
- Difficulties being with others - Negative experiences of others - Living in fearful isolation - Feeling stuck	- Attempting to cope with feeling bad - Attempting to make sense of experience - Taking a stand - Navigating relapse and recovery	-Links between CSA & Mental Health -Links between CSA & Psychosis -Psychosis & Shame

Table 1. Super-ordinate and sub-ordinate themes across participants.

Results

Interpersonal Difficulties

Participants described finding it difficult relating to other people in their lives at different times. Participants described experiences of isolation and that it was often difficult to trust people. Participants described a sense in which their difficulties with others, their withdrawal and isolation contributed to a sense of feeling stuck in their lives and of not moving forward.

Difficulties being with others

Participants described a sense in which they were avoidant of people. They used terms such as agoraphobia, shyness and lack of trust to describe significant and long term interpersonal avoidance.

> *I'm not good round crowds of people. I suffer from agoraphobia. That I can think is back from when I was at school. Irene P11.*

Negative experiences of others

Participants experienced significant and painful disappointment at the hands of their families, and 'professionals' over the years. Frustration and anger with others seemed closely tied to a feeling that others had failed to help or put an end to abuse.

> *I'm angry with the people for putting the fear of god into me, for not believing me…for allowing the sexual abuse to continue to have*

> *happened, for the bullying. I'm angry with the people for…being false. Irene P46*

Clare described a similar disappointment in her treatment by services at the time she was being sexually abused. She illustrated her efforts, disappointments and the personal legacy left for her to address in her adult years.

> *I put myself into care when I was sixteen, and I reported to the police, the social services, the NSPCC,… and em, they seemed not to believe me. … And, I felt totally let down by the system, and, not believed, not understood, not appreciated, not trusted. All these things that I've been feeling for so many years. Clare P3.*

Living in fearful isolation,

The negative experiences endured by participants often led them to withdraw from others in fear. Clare described this process beginning when she was a child, occurring after trying to tell her mother she had just been sexually abused.

> *… so I went into my room, and I sat there and I cried and cried and cried. And I think from that moment on I just decided even if it happens again I'll never tell anybody. Clare P8 .*

Clare also described the fear that she experienced almost all the time while she was a young person. She endured both regular sexual abuse in her home for a number of years, as well as relentless bullying at school. Her family's neglectful and abusive attitude to her meant that she went to school unclean and an easy target for bullies.

> *I was just totally... frightened. That's all I was. I was just frightened all the time. So I'd be like cowering in corners. And em, never saying anything. Clare P9- 10*

Feeling stuck

Participants described how difficulties with others, negative experiences of people and a need to withdraw oneself had led to a feeling of being stuck in their lives. Jackie talked about assertiveness and confidence, and how throughout her life she had felt short on both. She linked this to her abusive past, describing how a person learns to live within an unchangeable situation.

> *I think it might be the assertiveness. Like living with something that you can't make, you know you can't change. You're forced to live in that circumstance where you can't change it ...Jackie P39.*

Irene described considerable fear about achieving things and risking further disappointment.

> *It's a fear of achieving... what I want, there's always a fear that its not gonna come to fruitation [sic], because in my life there's always gonna be someone that's gonna destroy it. Irene P46*

Striving to Get Better

Participants' descriptions of their lives uncovered a huge burden of simply feeling bad. This was sometimes feeling bad 'about themselves', which is the subject of another theme (see 'Relationship with Shame'). For some, coping may have remained at a 'tactical' level given their resources and current situations. For others, a more 'strategic' approach could be discerned in their accounts of remission and recovering.

Attempting to cope with feeling bad

Jackie described how her attempts to feel better often involved drinking alcohol. For Jackie the evenings signalled an increase in anxiety and negative thoughts. She needed something that would help give her some space from her difficulties.

> *I think just to blank things out. Make things feel happy, in myself and blank out the night times. I used to drink until I could fall asleep with no problems. Jackie P31.*

Zoe described another process where she tried to use logic to reassure herself that things were ok. For her, some respite could be gained by checking and using a reasoned approach, but often this respite was short lived.

> *You know, sort of thinking someone might come in and assault me. But em, then I try and logicalize [sic] it, and I think 'is it possible, if they get through my roof, if they get through my door?' and I sort of check, I do that during the day as well…, sometimes and then I drift off into the same patterns of thought again. Zoe P14.*

Navigating relapse and recovery

All of the participants described a relationship with their own mental health /illness. Gains in mental health seemed difficult to attain and vulnerable to decay or loss. This gave a sense of insecurity and uncertainty to their lives.

> *When I was ill, I mean, I say when I was ill but I probably am over it now, I don't know coz I'm still on medication. Whenever I come off it I seem to have these experiences Clare P18.*

Clare articulated a dilemma where on the one hand experiencing well being and self understanding freed her from her psychosis. On the other hand, her understanding of the *experience* of psychosis, of the severity and force of it, meant that she doubted whether even her more self aware mind could withstand it.

> *I am worried that in the future I will get sick again, even though I've got to a stage where I feel like, sometimes I feel like I can't go back to that…*

> *I’ve learnt too much about myself...So, I hope that there won’t be any more incidents in the future but I don’t think that’s possible. I think it doesn’t really matter where you are in your mind, if you’re sick, you’re sick. And, that is a worry. Clare P19-20.*

Irene described her own relationship to recovery. Despite undertaking more therapeutic work at the current time, Irene outlined some of her misgivings concerning such an approach:

> *When I get counselling I thought to myself, oh god counselling yet again, what am I gonna get out of it. Its like climbing up one mountain, thinking you’ve got to the summit, and then you’ve got to climb up the mountain. I think to myself why do I bother. Irene P29.*

Zoe described a pattern in which she felt herself drifting in and out of feeling better and worse, her worries about relapsing and her day by day attempts to stay out of hospital.

> *I’m relieved that I don’t go there anymore. But there’s been in the last week or so, I felt ‘oh I feel so bad’ I thought I’m gonna end up back in there again. Zoe P12.*

Attempting to make sense of experience

The participants described processes whereby they attempted to understand what had happened to them. They were trying to make sense of psychotic experiences as well as of the sexual abuse perpetrated against them in childhood. Clare described a process in her life, where her sustained attempts communicating with others in groups and psychotherapy had helped her to gain some crucial distance from her own thoughts.

> *Yeh, you say it out loud and it just sounds so different to the way it is in your mind. Yeh? And then you think 'hang on, that sounds really mad' and then you can start to understand it. Clare P19.*

Irene described her understanding of how her abuse, psychotic episodes and mental health problems were linked together. Her understanding brought forward a concept of 'control' in her account as a central issue in terms of her abuse and mental illness.

> *It's got everything to do with my past. I was anorexic, because I had no control of my life. Em, I wasn't believed with what was happening when I was younger….with the sexual abuse. Irene P21 .*

Taking a stand

Sometimes the only way participants could get through each day was to struggle, either with themselves or with other people in their lives that were not acting in their interests. Jackie talked about her present struggles with depression and how she simply had to battle through each day.

> *I’ve gotta keep going, I’ve gotta keep doing what I’ve got to do. Coz I don’t want to really give up. I don’t want to just give up really. Jackie P3.*

Some of the women also spoke about a ‘core’ self that kept them together, or fighting to hold on, even in the midst of psychotic despair. Jackie again:

> *… and the voices were telling me I should do that. But it was me, and my self belief ‘but I’m not’ that stopped me from doing that. Jackie P9.*

Participants also described an increased sense of self-efficacy in their own lives. Jackie described an increased sense of agency and control, but one still coloured by depression:

> *… But now, I’ve started sticking up for myself saying ‘no sorry I can’t do that’ or…I feel more in control of meself. A little bit more happier, not feeling so trapped into things. Jackie P41.*

Irene used her lived experiences to distance herself from a discourse of medical labels such as ‘schizophrenia’.

> *What I've gone through in my life is my experience. I've gone through it. You cannot call me something that I'm not. Irene P40.*

Links between CSA & Mental Health

This theme focuses on links between CSA and mental health. Zoe explicitly described that she felt because of her experiences she found it very difficult to relate to or trust others. This might have formed a backdrop to her interactions with others.

> *Em, I find it difficult to trust people really, now. I find it very difficult coz of my experiences weren't very good. Zoe P7.*

Towards the end of her account, Zoe again explicitly stated how she felt the abusive experiences had impacted on her.

> *Eh, difficulty relating to people. Em, feeling I'm out of touch with things you know? Wondering if it's too late in my life, if I'll ever change and be happy. Just very isolated an isolated person really. And then, I've been taken advantage of aswell. And I'm very wary of what's happened, my experiences have not been good ones. Zoe P27*

Irene described in her account understanding how her abuse and other mental health problems were linked. Her understanding raised a concept of 'control' as a central issue;

this was in terms of her abuse, subsequent mental health difficulties, sense of being stuck in life and let down by professionals.

> *When I went into psychiatric care is because of my past. It's got everything to do with my past. I was anorexic, because I had no control of my life. Em, I wasn't believed with what was happening when I was younger….with the sexual abuse. Irene P21 .*

Here there is an understanding of her mental health difficulties as products of her abusive past; of having 'no control'. Anorexia is perhaps linked by Irene to the control of her own life and body. When Irene says: *'I wasn't believed when I was younger'* in this context she seems to emphasise a disempowered childhood. It seems that Irene was forced to 'show' her family and others that something was wrong; by starving her own body, and making her internal suffering external and painfully vivid for all to see.

Links between CSA & Psychosis.

This theme focuses on links between CSA and psychosis made by participants. Jackie described that she felt that there must be some kind of link either genetic or psychological between her childhood experiences of abuse and her later psychotic episodes.

> *I've got a cousin who's not all there either. He lives in ***** and he's had psychotic episodes. And like my sister as well and me. So it could be*

> *a genetic thing. But I don't think the abuse has ever helped, coz when I ever do have a breakdown or when I really get down in thoughts, it's always about that. It makes me get down. Like if I get suicidal it's always thoughts about that. Jackie P38.*

Irene made sense of her own unusual experience with reference to her own personal spirituality. In this sense, Irene's unusual experience of her now dead grandfather literally entering her mind/body became an opportunity for understanding.

> *It might sound stupid, but to me, this happened. Em, my Grandfather came to me and said he did what he did. He sexually abused me because he was sexually abused himself. Irene P33.*

One difficulty for Irene was her difficulty in making sense of her unusual experiences and her feeling that a spiritual protector could have allowed harm to occur to her in the first place.

> *I feel that there's some presence with me. Looking out for me, protecting me. Where the hell they were when I was being sexually abused, I don't know. Irene P3.*

Clare had made it clear that she felt that the content of her psychotic experiences was not related to her family. However, she articulated another more physically felt way in which she felt the abuse and the psychosis were linked. Her mental health problems including psychosis and her abuse seemed linked through an experience of feeling physically and mentally ‘crippled.’

> *Yeah, because basically the way I was abused was quite crippling. Em, it affected my body and my mind a little bit, you know…and that cripplingness. That feeling I had as a child. Of being crippled. Sort of downtrodden. I’ve had that in mental illness. I’ve had it so that literally my body is crippled. Where I can’t walk properly. Or I can’t see, or eh, hear things properly. Em, its sort of similar to being in that situation. Clare P12-13.*

Psychosis and Shame

This sub-theme relates specifically to the seemingly close fit articulated by participants between the content of their psychosis and notions of shame saturated selves. Zoe described an undefined negative quality that she felt she possessed which might have been related to her own pervasive sense of shame. In this context the accusation of being a ‘paedophile’ was placed upon her; arguably one of the most shame saturated labels in contemporary society. Her use of the phrase ‘I thought’ perhaps indicated that her own negative perceptions had shaped what she had heard.

> *I genuinely think people don't like me for some reason. And I don't know what it is about me, you know? I have no idea… there is a neighbour next door, and I thought he called me a paedophile… Zoe P3*

For Jackie, the stigma of being seen as a 'paedophile' also emerged. For her it was intimately bound up with her paranoid and psychotic thinking. In this instance, everybody seemed to be aware of her pariah status, thus amplifying the shame and stigma she felt to enormous proportions. It is worth noting here that neither women thought *themselves to be* paedophiles, simply that *others* thought they were, creating a perhaps blurred boundary between extreme paranoia and delusional belief.

> *I thought that I was a paedophile, and that everybody knew what I was…No I didn't think I was a paedophile, I thought everybody thought I was. Jackie P8*

In a similar way, some participants responded to abusive or psychotic experiences by employing logical reasoning that drew them towards concluding their own shamefulness was true. Clare articulated such a 'logic of shame' in the context of psychosis. She described an experience whereby:

> *…a woman was screaming and screaming and screaming and running away from me and keep looking back to make sure I'm not following her I was thinking to myself 'oh, … I must have done something really evil to*

> *this woman.' You know? For her to be running away. 'What did I do?' Clare P15-16.*

Clare spoke about how the logic of shame led her step by step towards its own logical conclusion, in this case, suicide. Fergusson and Mullen (1999) outline a number of recent studies that report extremely high odds ratios of adult suicidal behaviour following CSA (up to 74.0 in one study).

> *You're having all these thoughts..., where you're actually now thinking 'well, if I'm that evil, I must just kill myself now' you know? because I can't be evil. I don't want people to see me like that. I certainly don't want to be like that. So I'm just gonna kill myself. Clare P16.*

Discussion

This discussion will primarily focus on links both explicitly stated and implicit in the accounts of the participants between CSA, Mental health and psychosis.

LINKS BETWEEN CSA AND MENTAL HEALTH

Confidence

Participants felt low confidence may have originated in their childhood experiences of domination, betrayal and disappointment that characterised the abusive environments of the participants as children. Relatedly, Birchwood and Iqbal (1998), and Power and Dalgleish (1997) emphasise that poor self efficacy is an important aspect of feelings of entrapment following psychosis. Participants described how low self confidence may have directly impacted on their childhoods. In adulthood low confidence may have further interacted with among others: anxiety, depression, eating disorders and post psychotic appraisals of self efficacy. This may be linked to the participants' descriptions of a pervasive sense of separateness from 'normal' life.

Dissociation & Isolation

One major aspect of the accounts of participants was the extent to which they experienced isolation and dissociation during childhood and how this echoed their experiences of life in adulthood and is consistent with survivor literature (Herman, 1990). Dolan (1991) hypothesised that dissociating should be considered as symptomatic and dysfunctional, but also a useful coping strategy for CSA survivors during periods of stress throughout life. The women in this study described varying degrees of coping by blanking out details of abuse or blanking out other difficult aspects of their day to day lives. It may be useful to consider dissociation as variable, active and passive, and in correspondence to current mental health rather than fixed at a particular level. Lysaker and Lysaker's (2002) narrative structure of self suggested that psychoses represent a breakdown within an individual in the ability of self positions to communicate with one another. Accessing 'self-positions' may be impaired by processes such as dissociation which leave individuals feeling bereft of aspects of themselves, thus deskilling and isolating them further.

LINKS BETWEEN CSA AND PSYCHOSIS

Delusional & Hallucinatory Content

This study indicates that aspects of psychosis can be thematically or experientially similar to experiences of CSA. Bannister (1983), Garfield (1995) and Rhodes and Jakes (2004) have provided some evidence to suggest that psychotic content can be meaningfully linked (although causation cannot be directly inferred) to clients' current and past concerns. In this study some striking commonalities could be discerned in the content of psychosis such as references to paedophilia. The psychosis as described by the participants included images and voices that seemed to resonate with shame. Delusional content often included shame concepts or evoked beliefs about shame. Read et al. (2006) highlight two main possible pathways between CSA and psychotic experience. The first, described as the 'traumagenic neurodevelopmental model' outlines that children exposed to repeated trauma show persistent cortisol and dopaminergic irregularities in the hypothalamic-pituitary)-adrenal (HPA) axis. This may confer a heightened sensitivity or vulnerability to further stressors in the environment. The persistently high levels of stress in childhood described by the women in this study may be a reflection of these kinds of findings.

A second model is described by Read et al (2006) as 'decontextualised flashbacks'. Here sensory information is re-experienced, but impaired source monitoring in patients, due to repressed or dissociated memories, renders the flashback 'decontextualised' (i.e. without an identified precipitant) and therefore diagnosed as psychosis rather than post traumatic stress disorder (PTSD). In relation to the psychotic content, described by the participants in this study, Read et al.'s (2006) reading of the literature perhaps highlights that externalized source attributions (such as voices or hallucinations) may be forms of unconscious defense, whereby the brain is attempting integration of traumatic experience, without the fully affect laden re-experiencing of the memory of abuse itself.

Beliefs about a Shameful Self

One possible further impact of the psychosis was to exacerbate the negative, uncertain and shame saturated views of self that seemed to characterise participants' self appraisals. Such cognitive self appraisals are commonly found in the CSA survivor literature (Dolan, 1991, Herman, 1990).

Chadwick et al.'s (2000) findings concerning the beliefs clients hold about their voices, such as the degree to which the voice should be believed or acted upon, relate to this study. Highly shaming and accusatory unusual experiences may tap into negative and shame saturated self beliefs in individuals with significant histories of childhood abuse. This would also support Rhodes' and Jakes' (2000, 2004) findings that self evaluations are important aspect of the experiences of psychosis and Campbell and Morrison's (2007) suggestion that psychotic patients may often hold negative self concepts.

One mechanism for this might be related to the 'logic of shame' where the women in this study made conclusions following psychosis that were extremely negative and self-blaming. These findings would seem to point away from Bentall's theoretical position of delusions as a defence against low self esteem (Bentall, 2003) and towards Chadwick, Birchwood and Trower's (1996) concept of 'Bad Me' paranoia in psychosis, although it is recognised here that psychosis may operate differently in different individuals. It may be that survivors of CSA are more likely than other people with psychosis to have ‘Bad Me’ explanations for unusual experiences. For the women in this study, psychotic phenomena became another path to pre-existing and easily activated negative thoughts or schemas about themselves.

Limitations

The small number of participants in this study limits generalising from this sample to other women, or people with CSA histories and psychosis. This study is not able to infer causal relationships.

Clinical implications

This study supports recent work highlighting open discursive therapeutic practices in working with CSA and psychosis survivors (Herman, 1992, McGregor 2006, Larkin et al. 2006, Davidson 2003). Psychosis might be viewed following this study as having at least maintained or exacerbated pre-existing feelings of isolation, distrust, confusion, low self-esteem and physical ill health. Therapists should perhaps be open to incorporating the cognitive, emotional and physical sequelae of trauma histories in their formulations by engaging consistently and meaningfully with clients when they raise them in consultations (McCabe et al., 2002).

Participants described feeling stuck and fearful of setting or achieving new goals. Therapeutic interactions with such clients can seek to model and encourage healthy risk taking, assertiveness and validate clients' own attempts to connect with new people and projects (Rhodes and Jakes 2002).

Explorations of the impact of power discourses such as gender issues and the illness model are also raised by this study. Gender and power discussions may provide ways to reframe internalised or psychologised aspects of experience that perpetuate, for example, low self esteem or self blame. Explorations of the role of women or children in society and in families may uncover scripts or rules clients use to construct their notions of self. Discussions of diagnostic issues, for example, the 'sick role' or medical accounts of causality or prognosis, might also help clients explore the pros and cons of different identity positions as well as how they might be constructed or adopted (Holma & Alkonen, 1995: Johnstone, 2000: Wallcraft & Michealson, 2001).

The degree to which participants might draw on 'negative logic' in their appraisal of unusual experiences may be crucial in understanding the development of high risk behavioural correlates of psychotic experiences. The 'logic' of shame may implicate the role of cognitive therapy in working with and challenging self assumptions rather than focusing on psychotic phenomena per se (Larkin & Morrison, 2006: Rhodes & Jakes, 2002).

Future research

Future research could focus on men's experiences of CSA and psychosis to discern differences and similarities in relation to this study. For example, men have been reported to experience greater levels of sexual identity concerns and sexual dysfunction following CSA (Mullen and Fergusson. 1999). Further qualitative work examining the accounts of therapists' experiences of working with multiple trauma and psychosis histories would be a valuable addition to the literature. Also research may also wish to explore the notions raised by this study in relation to 'bad me' appraisals of psychosis and survivors of CSA. The question raised is: Are survivors of CSA different in their appraisals of psychosis to non abused psychotic patients?

Conclusion

This study has given a rich account of women's experiences of CSA and psychosis in adulthood. A new contribution of this study has been to integrate explorations of psychosis and CSA. This study suggests how psychosis and CSA can combine and reinforce each other through mechanisms such as shame, fear, isolation, and dissociation. Therapists can support client understanding of these interactions and build on existing healthy coping strategies.

REFERENCES

Bannister, D. (1983) The psychotic disguise. In W. Dryden's (Ed.) *Therapists' Dilemmas.* London, Harper & Row.

Birchwood, M., Iqbal, Z. (1998) Depression and suicidal thinking in psychosis: A cognitive approach. In: T. Wykes, N. Tarrier and S. Lewis (Eds.) *Outcome and innovation in psychological treatment for schizophrenia.* Chichester, Wiley.

Bogar, C.B. & Hulse-Kulacky, D. (2006) Resiliency determinants and resiliency processes among female adult survivors of childhood sexual abuse. *Journal of Counseling & Development, 84*, 3, 318-327.

Campbell, M.C., Morrison, A.P. (2007) The subjective experience of paranoia: comparing the experiences of patients with psychosis and individuals with no psychiatric history. Practitioner report. *Clinical Psychology and Psychotherapy, 14*, 63-77.

Chadwick, P.D.J., Birchwood, M.J., Trower, P. (1996) *Cognitive Therapy for Delusions, Voices and Paranoia.* Wiley Series in Clinical Psychology. Chichester, Wiley.

Chadwick, P., Sambrooke, S., Rasch, S., Davies, E. (2000) Challenging the omnipotence of voices: Group cognitive behavior therapy for voices. *Behaviour-Research-and-Therapy, 38*, 10, 993-1003.

Davidson, L. (2003) *Living outside mental illness: Qualitative studies of recovery in schizophrenia.* New York University Press.

Dolan, Y.M. (1991) *Resolving Sexual Abuse.* New York & London, W.W. Norton,

Fink, L. A., Bernstein, D., Handelsman, L., Foote, J., & Lovejoy, M. (1995). Initial reliability and validity of the childhood trauma inteview: A new multidimensional measure of childhood interpersonal trauma. *American Journal of Psychiatry*, *152*, 9, 1329-1335.

Garfield, D. A. (1995) *Unbearable Affect: A Guide To The Psychotherapy Of Psychosis.* New York, Wiley.

Grossman, F.K., Sorsoli, L., Kia-Keating, M. (2006) A Gale Force Wind: Meaning Making by Male Survivors of Childhood Sexual Abuse. *American-Journal-of-Orthopsychiatry, 76*, 4, 434-443

Herman, J.L. (1992) *Trauma and Recovery: from domestic abuse to political terror.* London, Pandora.

Holma, J., Alkonen, J. (1995) The self-narrative and acute psychosis. *Contemporary Family Therapy. 17*, 3, 307-316.

Herringshaw, L.R. (1997) Resilience and meaning: The development of concepts of self and world in adult survivors of childhood trauma. *Dissertation-Abstracts-International:-Section-B:-The-Sciences-and-Engineering*, *58*, 5-B, 2677

Hirschfield, R., Smith, J., Trower, P., and Griffin, C. (2005) What do psychotic experiences mean for young men? *Psychology and Psychotherapy: Theory, Research and Practice, 78*, 249- 270.

Janssen I, Krabbendam L, Bak M, Hanssen M, Vollebergh W, de Graaf R, van Os J. (2004) Childhood abuse as a risk factor for psychotic experiences. *Acta Psychiatrica Scandinavica, 109*, 38–45.

Johnstone, L. (2004) *Users and Abusers of Psychiatry.* 2nd Ed. Hove, New York, Brunner- Routledge.

Knight, Wykes, T., (2003) 'People don't understand': An investigation of stigma in schizophrenia using interpretative phenomenological analysis (IPA) *Journal of Mental Health, 12*, 3, 209 – 222

Larkin, W., Morrison, A.T. (2006) (Eds) *Trauma and Psychosis*. John Wiley & Sons, London.

Lysaker, P.H., and Lysaker, J.T., (2002) Narrative structure in psychosis: Schizophrenia and disruptions in the dialogical self. *Theory and Psychology, 12*, 2, 207-220.

McCabe,R., Burns, T., Priebe, S., (2002) Engagement of patients with psychosis in the consultation: conversation analytic study. *British Medical Journal, 16*, 325, 7373, 1148–1151

McGregor, K., Read, J., Thomas, D. (2006). Therapy for child sexual abuse: women talk about helpful and unhelpful therapy experiences. *Journal of Child Sexual Abuse*, *15*, 35-59.

Negrao, C., Bonanno, G., Noll, J.G., Putnam, F.W., Tricket, P.K. (2005) Shame, humiliation, and childhood sexual abuse: Distinct contributions and emotional coherence. *Child Maltreatment, 10*, 4, 350-363.

Perrott, K., Morris,E., Martin, J., Romans, S. (1998) Cognitive coping styles of women sexually abused in childhood: A qualitative study. *Child-Abuse-and-Neglect, 22*, 11, 1135-1149

Phillips, A., Daniluk, J.C., (2004) Beyond "survivor": How childhood sexual abuse informs the identity of adult women at the end of the therapeutic process. *Journal of Counseling & Development, 82*, 2, 177-184.

Power, M. and Dalgleish, T. (1997) *Cognition and emotion: From Order to Disorder*. Hove, Psychology Press.

Rahm, G.B., Renck, B., Ringsberg, K.C. (2006) ‘Disgust, disgust beyond description’ – shame cues to detect shame in disguise, in interviews with women who were sexually abused during childhood. *Journal of Psychiatric and Mental Health Nursing, 13*, 100-109.

Read, J., McGregor, K., Coggan, C., Thomas, D. (2006). 'Mental health services and sexual abuse: The need for staff training'. *Journal of Trauma and Dissociation*, *7*, 33-50.

Read, J., van Os, J., Morrison, A.P., Ross, C.A. (2005). Childhood trauma, psychosis and schizophrenia: A literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica*, *112*, 330-350.

Rhodes, J.E., & Jakes, S (2000) Correspondence between delusions and personal goals: A qualitative analysis. *British Journal of Medical Psychology*, *73*, 2, 211-225.

Rhodes, J.E., & Jakes, S (2002) Using solution-focused therapy during a psychotic crisis: a case study. *Clinical Psychology & Psychotherapy, 9*, 2, 139-148.

Rhodes, J.E., & Jakes, S (2004) The contribution of metaphor and metonymy to delusions. *Psychology and Psychotherapy: Theory, Research and Practice*, *77*, 1-17.

Sell, D.J., Stayner, D.A., Davidson, L. (2004) Recovering the self in Schizophrenia: An integrative review of qualitative studies. *Psychiatric Quarterly*, *75*, 1, 87-97.

Smith, J.A. Osborn, M (2003) Interpretative Phenomenological Analysis, Ch. 4 in: Jonathan A. Smith (Ed.) *Qualitative Psychology: A Practical Guide to Methods.* London, Sage.

Smith, J.A. (2003) Validity in Qualitative Psychology, Ch. 11 in: Jonathan A. Smith (Ed.) *Qualitative Psychology: A Practical Guide to Methods*. London, Sage.

Smith, J.A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1*, 39-54.

Wallcraft, J., Michealson, J. (2001) Developing a survivor discourse to replace the 'psychopathology' of breakdown and crisis, in: (Eds). C. Newnes, G. Holmes, and C. Dunn. *This is Madness Too: Critical Perspectives on Mental Health Services.* Ross-on-Wye, PCCS Books.

Willig, C. (2001) *Introducing Qualitative Research in Psychology: Adventures in theory and methodology.* Buckingham, Open University Press.

FOOTNOTES FOR THERAPEUTIC ALLIANCE ESSAY

[i] "Research studies problematically collapse numerous patients under a single diagnosis. It is a false and, at times, misleading presupposition in randomized clinical trials that the patient sample is homogenous. Perhaps the patients are diagnostically homogenous, but non-diagnostic variability is the rule, as every clinician also knows. It is precisely the unique individual and the singular context that many psychotherapists attempt to treat" (Lazarus, Beutler & Norcross, in Norcross, 2002, p23)

[ii] "The therapy relationship acts in concert with discrete interventions, patient characteristics, and clinician qualities in determining treatment effectiveness. A comprehensive understanding of effective (and ineffective) psychotherapy will consider all of these determinants and their optimal combinations" (Norcross, 2002, p441).