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

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Many thanks to the participants who made this project possible. Thanks also to Pieter Nel and John Rhodes whose support and encouragement have kept me on track. Finally, thankyou to all my family for their unceasing love, patience and warmth.

"...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.

[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, Zoe 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.

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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,
Stanmore
HA7 4LP.
Tel: 020 8909 5471
Fax: 020 8385 7151
e-mail: alison.okane@rnoh.nhs.uk

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

Alison O'Kane
Administrator

An advisory committee to North Central London Strategic Health Authority

Barnet, Enfield & Haringey Local Research Ethics Committee
R&D Office
RNOH NHS Trust
Brockley Hill,
Stanmore
HA7 4LP.
Tel: 020 8909 5318
Fax: 020 8386 7151
e-mail: alison.okane@rnoh.nhs.uk

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.

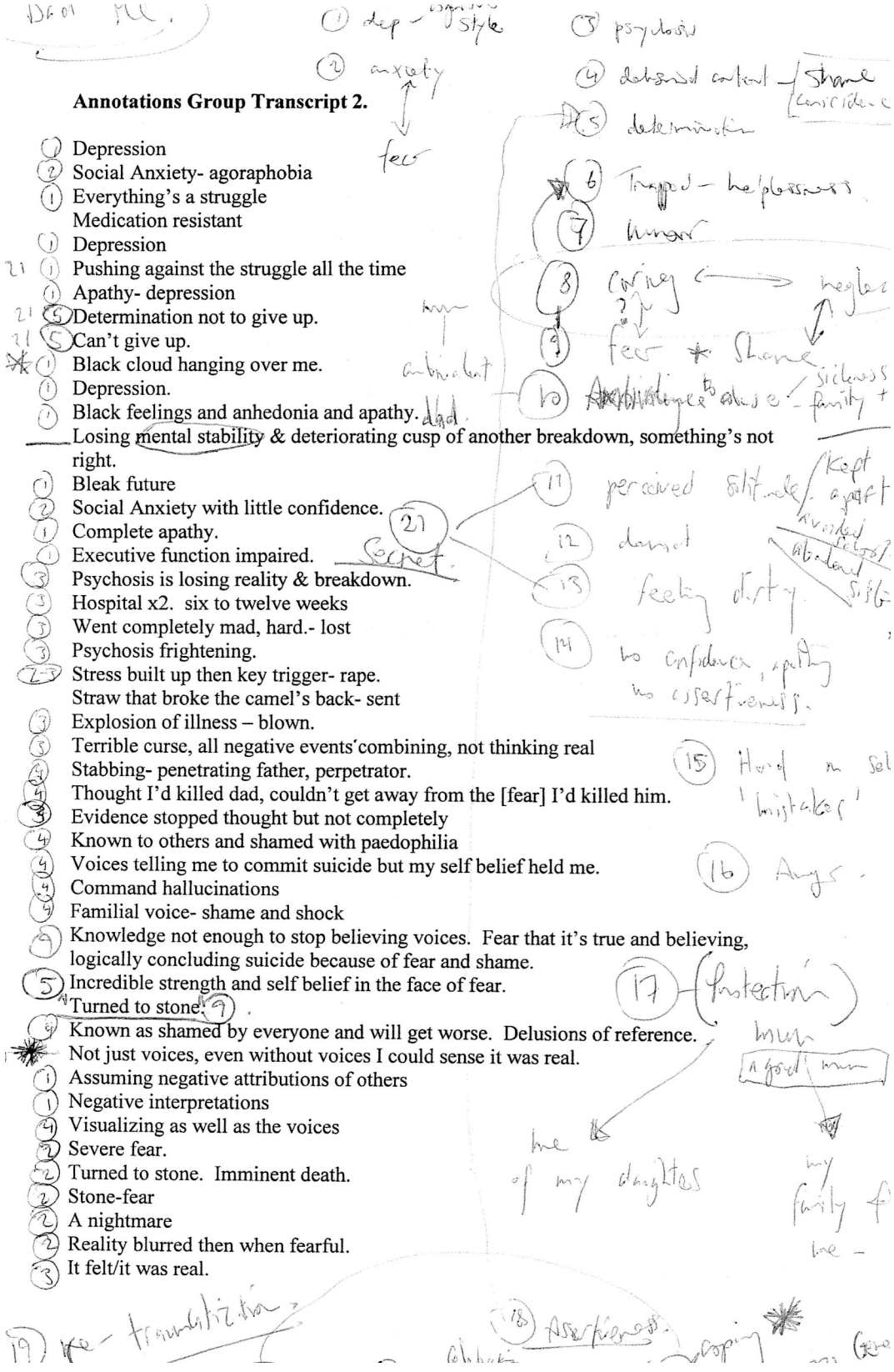
Appendix F. (Audit Trail)

Grouped annotations and emerging themes transcript 2

Emerging themes from transcript 2

Clustered themes and superordinate themes 2

Annotations Group Transcript 2.



Depression
Social Anxiety- agoraphobia
Everything's a struggle
Medication resistant
Depression
Pushing against the struggle all the time
Apathy- depression
Determination not to give up.
Can't give up.
Black cloud hanging over me.
Depression.
Black feelings and anhedonia and apathy.
Losing mental stability & deteriorating cusp of another breakdown, something's not right.
Bleak future
Social Anxiety with little confidence.
Complete apathy.
Executive function impaired.
Psychosis is losing reality & breakdown.
Hospital x2. six to twelve weeks
Went completely mad, hard.- lost
Psychosis frightening.
Stress built up then key trigger- rape.
Straw that broke the camel's back- sent
Explosion of illness – blown.
Terrible curse, all negative events combining, not thinking real
Stabbing- penetrating father, perpetrator.
Thought I'd killed dad, couldn't get away from the [fear] I'd killed him.
Evidence stopped thought but not completely
Known to others and shamed with paedophilia
Voices telling me to commit suicide but my self belief held me.
Command hallucinations
Familial voice- shame and shock
Knowledge not enough to stop believing voices. Fear that it's true and believing, logically concluding suicide because of fear and shame.
Incredible strength and self belief in the face of fear.
Turned to stone.
Known as shamed by everyone and will get worse. Delusions of reference.
Not just voices, even without voices I could sense it was real.
Assuming negative attributions of others
Negative interpretations
Visualizing as well as the voices
Severe fear.
Turned to stone. Imminent death.
Stone-fear
A nightmare
Reality blurred then when fearful.
It felt/it was real.

Unwell for longtime
I was her carer.
Emotional stuff- lots
Raped as a teenager.
Pregnancy
Kept secret
Rebelling, in a crowd rebelling
Made a mistake trusting the boy.
Went back to my secret
But wanted to have a baby
Didn't tell anyone about pregnancy, then not about rape but / so had to stay in contact with father.
Didn't tell anyone, mum maybe guessed, but was silent.
Let out secret when 'broken down' regrets this.
But couldn't help it.
Deep down- a secret- dirtiness deep down, not the same but similar
Painful ambivalence
Adept at keeping secrets and blanking them out- secret from others, and then self.(denial)
Turned to stone (i.e. paralysed by fear)
Reprimanded by dr.
Laughing at the litany of awful events.
Tried to be a good mum.
Protective, loving and educating.
Was coping ok until mum died
Big stepping block down.
Trapped again, just wanted to escape
Trapped and like a wife to him- sick expectations
Always trying when possible to abuse. Had to be on guard all the time.
Stress accumulates
Using booze and drugs
Losing control and not as good a mum as should have been.
Drinking nightly, still drink now.
Life spiraling out of control
Once out of the trap I tasted freedom and wanted to celebrate.
Not sensible.
A celebration of freedom
Exciting, doing all the wrong things.
Drinking and smoking, not there for my daughter- absent, blocking things out and being the teenager
Blanking out- not feeling negative emotions with drink- self medicating
Began to neglect daughter-guilt
Feeling guilty about actions- making mistakes
Daughter raped-blames self
Trigger to psychosis- rape and age- coincidence
Breakdown=psychosis
Meaningful link at the time
Increased significance of events
Extreme homicidal anger
Extreme anger triggered voices

But- logical reason 'put the knife down'
Voices changed
Paedophile theme-
anger to extreme anxiety- guilt
Unsure of events
Breakdown contains 'psychosis' and is a gradual process
Persistent anxiety
I make big mistake(s)
Mistrust of own judgement?
Could change situation- heartache
Police finally involved
All over, still angry but awareness that high affect not healthy
Drinking – self medicating
Noisy thoughts- anxious
Quiet thoughts- calmer
Worrying worrying worrying a lot
Heavy burden of care for dad
Ambivalence towards caring for dad
Feels lumbered by family
Trapped again
Trapped with some control
Feel 'not so trapped'
Genetic link
Genetic because sister effected also
Privation of assertiveness- learned helplessness
Never forget or get over abuse
Even if genetic the abuse 'has not helped' whenever down thoughts turn to abuse
Self concept limited to not assertive
Tread all over- like a doormat
BUT feels some assertiveness
No sense of entitlement
Down now, but not as bad as the past, have more control now.
Control over thoughts, feelings and behaviour
Acknowledged by others now
Not so trapped more control happier
Social Anxiety
Forever dirty (inside)
Enjoys family – caring for others important
Career, opening a new chapter
Future is bleak. Poverty, drink, an old lady. Hopefully no breakdowns.

Suffocated and trapped
By abuser
Trapped, gallows
Humour
Still caring despite abuse
Abusing is a sickness- an excuse
Happened to all the sisters-ignorant of this
Perceived solitude in abuse.
Every night. Horrible
A [black] cloud came over him.
Frightening horrible experience
8 years
Frightened to tell coz of consequences.
Scared to tell about abuse, denied it at first.
Wanted dad to go to prison, but not to be killed,
Dirty feeling, no confidence, apathy and rebellion.
Holding onto a dirty secret always. Avoided school- separate from others- looking after mum.
Little schooling
Hard on self- should have worked.
Kept separate from others.
Strict upbringing
Sheltered from life laughing [word play]
Sisters left me with him.
Still not close.
Other sister has mental health probs.
Mum intervened to stop abuse.
Felt safer, but still endured milder abuse.
Emphasises safe.
No police.
Ambivalence to mum, she should have done more, but she tried her best.
Angry that I had to go through that unnecessarily.
Paedophiles sick born that way [but] I'd kill someone that did it, unlike mum.
Stronger than mum
Sickeningly soft behaviour rewarding barbarity.
Guilty laugh at disliking father.
Family disregarded my wishes and minimized impact, they loved him [despite his barbarity]
I have ambivalence to him also.- sickness not his fault.
Hard to hold the ambivalence.
Particularly when he doesn't acknowledge his guilt or the impact.
But I don't want to hurt him
Mum died and depression started.
Trapped [again] no protection
Daughter vulnerable
Fearful for and protective of daughter
Had to leave which was hard. Put foot down wouldn't leave my daughter with him.
Left home just after mum died
She protected me
Not sudden, long process

Transcript 2. Emergent Themes.

Remember- 'poor me-bad me' Trower and Chadwick.

1. Issues around depression, negative cog. Bias.
2. Anxiety and fear- abuse and delusions
3. Psychosis and delusional content- coincidence-trigger, protection-trigger, fear, family voices / thoughts, death of dad, paedophile, shot at, shamed, transparent.
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.
7. Caring and protection.(KEY THEME) 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.
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
14. Anger – absent, but vengeful in psychosis (out of character).
15. Re-traumatization- abuse, rape, birth, daughter's rape.
22. Genetic causality vs event causality, not sure.
23. Ambivalence to self, mum, dad, family.

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
	(1) **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 (10)	
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
	(20) 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 (30)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. 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?	Pushing against the struggle all the time
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… N- Yeh, and when you pu, but there's something also about that you kind of have to push yourself… (30)M- Yeh	Apathy- depression

	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.	
	(10)	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.	(20)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…	
	(30)	
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?	
Not mentally stable now. Something's not right.	(20) 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… M- mm N- And you mentioned having no motivation, or very little. Would you say there's no motivation there, or….?	Social Anxiety with little confidence.
	M- Yeh, there's no motivation there…	Complete apathy.
Hard to make plans and carry them out	(20)N- really? M- Yeh, It's very hard for me to make plans and carry them out. 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?	Executive function impaired.
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 (10)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 (20)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 (30) 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. N- Right….Can you remember why you, or what evidence you had at the time for that thought?	Stabbing- penetrating father, perpetrator.
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. N- Did he, sorry to interrupt, when you saw him, did that stop that thought?	Thought I'd killed dad, couldn't get away from the [fear] I'd killed him.
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… M- No it stopped that thought. N- Right, And did you have any other ones?	Evidence stopped thought but not completely
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. N-ok. So there was some voices that were commenting, and saying things. (10)M- Yeh. N- Were the voices there with the dad thought as well? Were they….	Voices telling me to commit suicide but my self belief held me.
Voices there a lot	M- Yeh, yeh, the voices were there aswell. 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?	Command hallucinations
Voices known. Shaming, shock	(20)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. 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. (30) N- Was that the same with the killing dad one. Did you think that you	Familial voice- shame and shock

	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 (10)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… (20) 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 (30) 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. N- Do you have a sense of, again, of what gave you or made you… it (10) 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…	Known as shamed by everyone and will get worse. Delusions of reference.
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. (20) 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 (30) 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
	(10) 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.
	(20) 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	
	(30)	
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 N- And, so, it feels like a dream now. M- mm N- And at the time?...	when fearful.
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 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	
Suffocated and pushed into being with dad.	(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	Suffocated and trapped By abuser
He was abuser	with my dad, but I've got problems coz he was the one who sexually abused me. 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. (10) 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. N- Yeh M-But yeh, that was going on for some years. I never really spoke up (20) 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. N- Right, yeh… M- So we couldn't go that way. (30) N- Is this in Jamaica, or in the UK?	8 years Frightened to tell coz of consequences. Scared to tell about abuse, denied it at first. Wanted dad to go to prison, but not to be killed,
Sister asked about it. Broke down when sharing. I wanted him to go to prison.		

6-14 Feel dirty, not confident not interested in learning- a rebel. Dirty secret all the time. Stayed off school a lot.	M- No this is here. N- In the Uk M- Yeh N- And how old were you when you're sister was asking you? (10)M- I was about 14 then. N- Right 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? M- At school, I used to go to school and feel dirty. And em, I didn't have (20)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. N- really? 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. N- Right (30) M- So, em, I did hardly go to school really, looking back.	Dirty feeling, no confidence, apathy and rebellion. Holding onto a dirty secret always. Avoided school- separate from others- looking after mum. 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.	
	(10) 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.	M- We were always kept, we weren't allowed to play out or, we could (20) 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	Kept separate from others.
Sheltered and kept away from everybody.	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].	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.	(30) 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 . 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. (10) N- Yeh, and you're elder sister that asked you about the abuse, had she left home by then?	Sisters left me with him. Still not close.
Not as close to sisters as would like. One sister has MH probs. Other sister ok	M- Yeh, she'd left home by then. But she herself suffers from mental health now as well. N- Does she? M- Yeh, my other sister, she seems to be un-scathed, she seems to have come through it ok. (20) 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?	Other sister has mental health probs.
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 (30) 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.	Emphasises safe.
Repetition of safe.	M- I did feel safe.	
	N- Em, that sounded like mum had said, sort of, about not taking it to the (10) 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?	
	(20) 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.	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 (30) 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 it at all. Mum did the best she could tho.		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 (10) 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… N- Right.	Paedophiles sick born that way [but] I'd kill someone that did it, unlike mum.
I'd have been stronger.	(20)M- I think I'd have been a bit more stronger. N- Yeh. Why, why the difference?	Stronger than mum
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. N- Yeh.	Sickeningly soft behaviour rewarding barbarity.
I'm stuck looking after him	(30) 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. N- Why do you say that, that you shouldn't say it?	disliking father.
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 (10) 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. 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	Family disregarded my wishes and minimized impact, they loved him [despite his barbarity] I have ambivalence to him also.- sickness not his fault.
	(20) M- Yeh, it is, it is very hard to hold the two things together. N- How do you do it?	Hard to hold the ambivalence.
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. (30) N- Yeh, is, is your mum still around?	Particularly when he doesn't acknowledge his guilt or the impact. But I don't want to hurt him

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
	(10)	
	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
	(20)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.	
	(30)	
	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. N- You said that you were quite rebellious at school…	Rebelling, in a crowd rebelling
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 (10) 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… N- mm, yeh…	Made a mistake trusting the boy. Went back to my secret But wanted to have a baby
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 (20) 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. N- Mm, and did anything happen about that it was a rape.	Didn't tell anyone about pregnancy, then not about rape but / so had to stay in contact with father.
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. (30)N- And even now, you still haven't told many people?	Didn't tell anyone, mum maybe guessed, but was silent.

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. N- Yeh, ok…	Let out secret when 'broken down' regrets this.
Regrets telling people.	M- Which I regret, but I couldn't help really coming out with 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' (10) M- Yeh… N- Can you explain sort of what you mean by that?	But couldn't help it.
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. N- Yeh, what's that feeling like (20)	Deep down- a secret- dirtiness deep down, not the same but similar
Awful, I wanted to tell someone.	M- It was awful, I wanted to tell somebody. Yeh, I did want to tell someone. 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…	Painful ambivalence
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 (30)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.		others, and then self.(denial)
	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?	
Traumatic birth	M- Yeh, yeh, that was really traumatic.	
	N- Was it?	
	(10)	
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…	
	(20)	
Laughs again at terrible events.	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	Laughing at the litany of awful events.
Tried to be a good mum.	make sure she was well cared for and everything.	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.
	(30)	
	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. N- What was life like in that period in sort of twenties to thirty.	Stress accumulates
Started alcohol and cannabis	(10) M-Well, I started drinking alcohol, and smoking Ganja, N- Right.	Using booze and drugs
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. N- What sort of amounts are we talking about here like? What kind of, how much alcohol, was it kind of like a lot….?	Losing control and not as good a mum as should have been.
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. N- Yeh,	Drinking nightly, still drink now.
Life started spiraling out of control	M- But em, yeh, my life started spiralling out of control really, I was… N- What, what do you mean by that? What is, what were the bits that (30)were spiralling out of control?	Life spiraling 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)	(10)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 (20) 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 (30)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] 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?	and being the teenager
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 (10) 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 (20)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. (30) 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 (10)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.	(20) 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 (30)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 (10) 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.. (20) 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 (30) 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 (10)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 (20)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. (30) 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… (10) 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 (20)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 (30)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.	(10)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. (20)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. (30) 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]	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	
[either way] the abuse has not helped. Whenever down its always about that. Suicidal always about that.	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. (10) 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. (20) 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? (30)	
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 (10)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…	
Enjoying my grandson and get a little career going.	(20)N- Oh wow! Goodness, lovely. 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. (30)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

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

Item Response Scores

	Never True	Rarely True	Sometimes True	Often True	Very Often True	MI Score on item as scored on an ite
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	

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)

Minimization/ Denial Scale Total Score (0–3)

_____ _____ _____ _____ _____ Classification

_____% _____% _____% _____% _____% Percentile Rank (Reference Group: _____)

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