

DOCTOR OF PHILOSOPHY

Understanding the lived experience of childhood trauma amongst adults with mental health problems

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Award date:
2018

Awarding institution:
Coventry University

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Understanding the Lived Experience of Childhood Trauma amongst Adults with Mental Health Problems.

By

Robert Tummey

November 2017



*A thesis submitted in partial fulfilment of the University's
requirements for the Degree of Doctor of Philosophy*

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Acknowledgements

Throughout the PhD journey there are a number of people who provide support on a small or a large scale. They are the backbone to the whole process, which would not come to fruition without them. They are many and they are specific. I will always remember their input and their encouragement.

I would like to thank all the participants for the privilege of their time, the honour of their company and the confidence of their story. The mental health charities that provided the opportunity for me to meet and greet a wide range of people involved in their services and access their facilities for the purpose of providing a safe, mutual environment to meet: Cathy Berta at MIND, Craig Weeks at Rethink Mental Illness, Sheila Marston at Actively Influencing Mental Health Services (AIMHS) and Sandeep Dhesi at Making Space.

Thank you to Coventry University staff for supporting my efforts. Firstly, I owe a huge debt of gratitude to my Director of Studies: Dr. Tony Colombo, who taught me to write well, provided support and guidance, and maximised my potential. Special thanks to Prof. Paul Bywaters as part of my supervision team. Also, Prof. Rob James, Julia Crisp and especially, Diane Phimister. Further to this, huge thanks to my colleagues for their unrelenting support. Ray Bell, Fazilah Twining, Yvette Brown and Jon Andrews who covered my work, gave me a push when needed and always listened.

Also, thank you to the IPA community at the University of Warwick, especially Dr. Deborah Biggerstaff and the online community at IPANALYSIS.

To my friends, who never understood where I was, what I was doing or why I was taking so long. Thanks Rob and Louise Green, Ian Hayward, Neil Partridge, John Allsop and Mark Baller.

To the most important people in my life: my family. Thank you to my wife Francesca, for giving me absolute support to achieve this, the space to grow and the impetus to finish. Regardless of anything else, I could not have done this without you. Also, thanks to my children Hannah and Rhys, for their encouragement and understanding throughout. Finally, thanks to my Mom for her belief.

This thesis is dedicated to my grandfather George, who taught me to walk tall.

Also, four generations of strong women in my life who teach me every day:

Florence, Dilys, Francesca and Hannah

Declaration

This thesis is submitted to Coventry University in support of my application for the degree of Doctor of Philosophy. It has been composed by myself and has not been submitted in any previous application for any degrees.

The work presented (including the data generated and the data analysis) was carried out by the author.

Abstract

Study Aims: The purpose of this study is to investigate the lived experience of childhood trauma amongst adults with mental health problems. The specific aim is to understand these abusive experiences in terms of their various forms (nature), when and how they started (causes), the efforts made by survivors to protect themselves from such abuse (coping) and the long-term consequences into adulthood (impact).

Methods: The study is organised around the principles of interpretative phenomenological analysis (IPA) employing semi-structured interviews. The homogeneous sample population included 15 participants who satisfied the inclusion criteria: 1) being over 18 years old; 2) having a mental health problem; and 3) self-identifying as suffering some form of childhood trauma.

Findings: The IPA analytic process highlighted a number of superordinate themes. Participants talked about their experiences of childhood trauma in terms of a range of physical, sexual, emotional and neglectful forms of abuse. Moreover, these traumatic experiences did not represent isolated incidents but were typically interpreted as: pervasive, varied and continuous throughout their childhood. In an effort to deal with these multiple forms of abuse a range of coping strategies were attempted including: avoidance of others through self-isolation; the formulation of cognitive distortions through the construction of an 'imagined world'; and retaliation against the self (through self-harm and suicidal ideations, plans or attempts) or against others. Participants also talked about the profound impact these traumatic experiences continued to have on their lives, especially how such abuse had: completely undermined their sense of self; forced them to live an isolated existence, marginalised from the social world around them; and had left them lacking any sense of positive psychosocial wellbeing.

Conclusions: It is argued that these traumatic childhood experiences significantly undermine existing social attachments and participants' ability to develop positive attachment styles. In turn, these poor attachment skills affect their social and personal relationships throughout the course of their lives. Furthermore, it is suggested that the post-traumatic consequences of their childhood experiences have a profound effect on: their cognitive functioning through a deficit in memory, learning and perception; generating a pervasive sense of hopelessness that there is no future, no alternative options and that nothing will change; and their ability to remain resilient drains as they attempt to cope and adapt to adversity. Through employing these varied theoretical interpretations of the findings, a speculative outline of an explanatory psychosocial model is presented which attempts to understand why some people who are traumatised as children are at risk of developing mental health difficulties during adulthood.

Implications: In terms of policy and practice outcomes: 1) There needs to be greater psychosocial emphasis in mental health recovery; 2) The nature and impact of childhood trauma needs to be more thoroughly considered in terms of mental health assessments; 3) Attachment-based strategies could be considered in therapeutic interventions; 4) Greater priority given to enhancing personal and social resilience through safeguarding, improved parenting and social quality.

A Poignant Participant Quote from Amelia:

'It Impacts Your Soul'

Amelia: *"I think a lot is circumstance... You can't control who your family is...and I think that when bad things happen... **it impacts your soul** and it affects how you respond... and how you interact... I mean often... mental health... that has impact... from trauma as a child... I mean I don't know... and don't really understand... you know, how it alters your thinking and what have you... but, I suppose it has to... There's only so many times you get knocked down and not get back up again..."*

Int: *Mmm*

Amelia: *"You know... and I suppose I was one of these that just kept getting up...waiting for the next punch sort of thing... So, I think **it impacts your soul** and that **impacts how you react and respond to people around you**... but I think throughout life, there is always going to be bullies around... regardless of how you act and react..."*

Int: *Mmm*

Amelia: *"You're going to have people who will see a weak spot and they will go for it... and I think those sort of people... you can't really, you know... control what happens... because they've got their own agenda... I mean I suppose if you look at what happened when I was a child... **sexual abuse wasn't talked about** and if you did talk about it... you were a liar... you know... and the **circumstances were ideal... really**, for that to happen..."*

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Introduction

The purpose of this study is to investigate the lived experience of childhood trauma amongst adults with mental health problems. The specific aim is to understand these abusive experiences in terms of the following research questions:

1. What was the nature of the childhood trauma experienced by participants?
2. What did participants consider to be the cause of their experiences of childhood trauma?
3. What coping and adaptation strategies (if any) did participants employ?
4. What impact (if any) did their experiences of childhood trauma have on their adult lives?

Childhood trauma is the early experience of uncontrollable stressful events (Zlotnick et al. 2008). According to Briere et al. (2008), these range from trauma experienced through a life event such as traumatic bereavement, through to child maltreatment. The World Health Organisation (WHO) states that child maltreatment (formerly child abuse) is the emphasis to harm as a result of the four main abuses (WHO 1999). These include i) Child physical abuse: Actual or potential physical harm from an interaction or lack of interaction; ii) Child emotional abuse: Failure to provide a developmentally appropriate environment that includes a primary attachment figure. Also acts towards the child that cause harm, such as rejection, restriction, patterns of belittling, scaring or ridiculing; iii) Child sexual abuse: Inducement or coercion of a child to engage in unlawful sexual activity; and iv) Neglect: Failure to provide for the development of the child within all spheres of their well-being.

It is reported by WHO (2016) that a quarter of all adults have suffered child abuse. In the United Kingdom, there are currently over 57,000 children identified as needing protection from abuse (NSPCC 2015a). However, in Bentley et al. (2016) comprehensive overview of child protection, they believe that for every one child identified, another eight are suffering abuse. In recent times child abuse has also been subject to a shift in public awareness, following high profile child abuse cases such as Daniel Pelka (CSCB 2013: Serious Case Review) and the sex abuse scandal involving Jimmy Savile (Gray and Watt 2013).

The long-term consequences of childhood trauma include impaired mental health and social outcomes (WHO 2016), relative to the general population (Varese et al. 2012). However, adults presenting with formal mental health symptoms are usually interpreted through a biological aetiology. As a result, the associated psychiatric diagnostic label becomes the most dominant characteristic. It defines their whole social identity and appears to confine them to a restricted function within the psychiatric system. One consequence is that the roles of other psychosocial explanations are not fully considered. This study aims to investigate the influence of personal and social functioning on the experiences of adults with mental health problems and a history of childhood trauma. Mental health problems include diagnostic disorder categories of anxiety, depression and psychosis. Childhood trauma is inclusive of the description above.

There is a paucity of research on this topic (Manning and Stickley 2009; Read et al. 2005) and the existing body of literature is overwhelmingly positivist. As such, the qualitative voice of the person with lived experience is lacking. Therefore, a phenomenological method will be utilised to access individual lived experience of the phenomenon. To move beyond phenomenological description, a hermeneutic approach is necessary. Interpretative phenomenological analysis (IPA), as described by Smith et al. (2009) combines both. This approach is suited to studies that aim to explore in depth, the complexity of personal meaning attached to the experience of interactions within the environment (Smith et al. 1999; Kay and Kingston 2002) and relate the findings to possible clinical implications (Smith 1996; Willig 2001; Smith 2004).

Rationale

This section will explore the six main reasons for conducting this study: 1. To add to the empirical evidence through qualitative investigation; 2. To gain understanding as to how childhood trauma impacts on personal and social resources across the lifecourse; 3. To understand the impact of personal and social functioning on adult mental health outcomes; 4. The use of IPA to promote the voice of the participant and interpret the impact of their lived experience in a meaningful way; 5. Findings could have value to service users in helping situate their life experience within the context of trauma and social functioning; 6. Findings could have a positive impact on therapeutic treatment and support services, and provide an ideological

shift away from conceptualizing mental health status as causing psychosocial difficulties towards considering the inverse to be true.

Structure of Thesis

The thesis will follow a traditional structure organized around three sections; namely, Part One: Literature Review; Part Two: Methodology; Part Three: Findings and Discussion.

Literature Review

Childhood Trauma and Mental Health Problems: All of the studies found a statistically significant association between childhood trauma and adult mental health problems. Adults with a psychiatric diagnosis are significantly more likely to have experienced at least one type of childhood trauma or abuse (Alvarez et al. 2011; Perales et al. 2013; Pirkola et al. 2005; Gibb et al. 2007; Spila et al. 2008; Maniglio 2013). Many will have experienced a combination of traumas and even multiple traumas in childhood, further increasing their risk of poor mental health outcomes. For example, Moskvina et al. (2007) found 55.6% of a clinical population reported two or more traumas and Sesar et al. (2010) found 74% of a student population identified more than one trauma. A minimum of three types was reported in up to 47% and at least four by 18.5% in both clinical and community samples. Gibb et al. (2007) suggest that multiple traumas are the norm for child abuse, with Green et al. (2010) identifying a mean average of 3.2 in participants with more than one childhood trauma. This leads to disproportionately poorer adult mental health (Schilling et al. 2008).

Theories of Influence: Various theories are considered from psychological literature to explain the connection between childhood trauma and mental health problems. For example, theories such as Social Defeat Theory (Bjorkqvist 2001, Kovalenko et al. 2014) are helpful in focusing on the surrender of an individual to an environmental influence. Learned Helplessness (Overmier 2002) explains a surrender of autonomy; Hopelessness Theory (Abramson et al. 1989) considers attributional style of thinking associated with depression and suicidality; and Resilience Theory (Fletcher and Sarkar 2013) highlights a positive attempt to overcome adversity. Also, Cognitive Theory considers developmental deficit (Hedges and Woon 2011) and distorted perception (Beck 2008), Theory of Dissociation (Janet 1889) as a psychological

defence (Van der Hart and Horst 1989), and Psychodynamic Theory (Greenhalgh 1994) explained through coping mechanisms (Rice and Hoffman 2014).

Some theories provide understanding of an influence on certain developmental aspects, but not sufficient alignment to fully explain the continued impact of childhood trauma on the lifecourse of people with mental health problems. There are valued contributions from all of the theories, but the most meaningful and dominant appears to be attachment theory (Bowlby 1969, 1988). For example, Bowlby (1977) first conceptualized that human beings make strong affectional bonds to particular others. Disruption of such attachment bonds can impact on the child in a negative way through insecure attachment; felt across the lifespan (Bowlby 1980; Lopez and Gormley 2002) and influencing transitional adjustment processes (Lopez and Brennan 2000).

Attachment theory identifies the child as 'wearing' their insecure attachment style in familial, social and all personal encounters. Insecure attachment style can be adapted and progress to a secure attachment style (Iwaniec and Sneddon 2001; Zhang and Labouvie-Vief 2004). However, this requires successful navigation of adult social milestones and improved emotional environment (Caspi and Elder 1988). Some people with adult mental health problems and a history of childhood trauma may not have experienced such developmental goals. Instead, insecure attachment style may remain across the lifecourse, supported by other psychosocial deficits.

Childhood Trauma, Attachment Theory and Mental Health Problems: All studies found a significant association between childhood trauma, insecure attachment, and poor mental health outcomes. Some focused attention on the increased risk of insecure attachment style as a result of childhood trauma (Cloitre et al.2008; Alexander 2009; Muller et al. 2012). Some determined an increased risk of poor adult mental health outcomes as a result of insecure attachment (Berry et al. 2007; Ivarsson et al. 2010; Ponizovsky et al. 2013). Research shows that the combination of childhood trauma and insecure attachment is predictive of new episodes of mental disorder (Bifulco et al. 2006). Indeed, similar research by Stovall-McClough and Cloitre (2006) found a 7.5-fold increase in poor mental health outcomes.

Methodology

Qualitative methodology is used to undertake the research, with the research design drawn from IPA. The theoretical underpinnings of IPA stem from Husserl phenomenology which originated with hermeneutics (the theory of interpretation), and with symbolic-interactionism (Smith et al. 2009). Smith (2004) believes that only through an interpretative process can meanings ascribed to an event be accessible. IPA has an identified epistemological stance, that through careful and explicit interpretative methodology, the researcher can access the cognitive inner world of an individual. This is a prime distinction between IPA and other methods. As a phenomenological approach, IPA aims to explore in detail participant lived experience and how they make sense of that lived experience. This involves moments of seeing meaning through what Heidegger (1953/2010) termed 'Dasein', translated literally as 'there-being' (Mulhall 2005). Therefore, Dasein will illuminate the social experience. IPA is interpretative and strongly connected to hermeneutic tradition (Palmer 1969). The characteristic features of IPA are captured in three broad elements: idiographic, inductive and interrogative (Smith 2004).

Findings

This section details the analysis of the qualitative data and provides a comprehensive view of the findings. Results are organized into three chapters based on three emerging master themes: 1) The nature of traumatic experience, 2) Coping and adaptation and 3) The impact of childhood trauma. Superordinate and subordinate themes help illuminate a more detailed understanding of each master theme through participant narrative. Each theme is identified and presented with the participant voice central in the presentation.

Discussion

Researcher interpretation and discussion are provided including consideration of the extant psychological literature and attachment theory. In addition, the findings are considered within the context of several theoretical frameworks. This enables a combination of frameworks to provide a new psychosocial explanatory model, detailing four stages between childhood trauma and adult mental health intervention. Finally, policy implications identify possible ways practice adaptations for the new model are already taking place and can be further exploited.

Conclusion

This introduction provided an overview of the study as a whole. The next section is Part One: Literature Review, with chapter 1 a systematic review of the literature to explore the association between childhood trauma and mental health problems.

PART ONE

REVIEW OF THE LITERATURE

Part one presents the literature review for this study. Three chapters provide insight into the research literature that emerged during the process of review. Each chapter represents a progressive understanding of the current extant literature exploring the association between childhood trauma and mental health problems:

Chapter 1 provides a systematic literature review that explores recent research studies focused on intra-familial childhood trauma and its association with adult mental health problems. Key findings from the literature are organised into themes for further discussion. The first establishes if there is an association between childhood trauma and mental health problems. The second identifies patterns in the association across the breadth of the review. Finally, consideration is given to the forms in which childhood trauma and mental health problems are experienced.

Chapter 2 explores eight of the most relevant theoretical frameworks from psychological literature. This is to ascertain possible connection between the experience of childhood trauma and the onset of mental health problems. Each theory is scrutinised for its value in providing an explanation to further understand influential forces assisting in the process of decline.

Each theory discussed in Chapter 2 offers important explanatory accounts of the relationship between childhood trauma and adult mental health problems. However, recent research and scholarly attention has focused on the significance of attachment theory. To develop a more comprehensive understanding of this work, Chapter 3 provides a systematic literature review focused on the association between childhood trauma, attachment theory and mental health problems.

Chapter 1

Exploring the Association between Childhood Trauma and Mental Health Problems

The aim of this systematic literature review is to explore the association between childhood trauma and adult mental health problems. The chapter starts with an explanation of the research strategy employed. This will provide information on how key studies were found through the process of inclusion and exclusion criteria employed and the quality assessment undertaken to ensure robust, relevant research was considered. An overview of the literature is then presented, detailing the characteristics of the studies and the key findings from the literature as a body of research. This will be organised around 3 main themes drawn from the literature. The chapter concludes with a consideration of the current state of knowledge on the relationship between childhood trauma and mental health difficulties, and how identified gaps in the literature might be addressed.

Methods

Search Strategy

A systematic search of the literature was undertaken between January 2015 and June 2015. The review began with a thorough computer search of the most relevant health and social sciences data bases (Younger 2004). These included Academic Search Complete, AMED, CINAHL, Medline, PsycArticles, and PsycInfo. A hard copy search was undertaken to consider the reference list of each study identified.

Table 1.1: Search Terms for Childhood Trauma and Mental Health Problems

Concepts:	Variation/Synonym:	Location:
Child Abuse	Childhood Abuse Childhood Victimization Childhood Adversity Childhood Maltreatment Childhood Trauma Child Sexual Abuse Child Emotional Abuse Child Physical Abuse Family Abuse	Title Abstract No Field Selected
Connection	Causes of Experience Relationship	No Field Selected
Mental Health Problems	Mental Illness Mental Disorder Psychosis Adult Mental Health Problems	Title Abstract No Field Selected

As identified in Table 1.1 the first search commenced using key word search of three classifiers of ‘child abuse’ and ‘connection’ and ‘mental health problems’, suggested by Ely and Scott (2007). The Boolean operator ‘and’ was the only additional word used to combine all three classifiers throughout the search to look for articles that include all identified keywords (Cronin et al. 2008). The exercise was then repeated with the classifiers altered to incorporate different synonyms in use across the literature. Variations commenced with childhood abuse, childhood victimisation, childhood adversity, childhood maltreatment and childhood trauma. Connection was replaced by synonyms ‘causes of’, ‘experience’ and ‘relationship’. For mental health problems, the words mental illness, mental disorder, psychosis and adult mental health problems were added systematically to elicit further studies. The location of the key word within the database search commenced using the field, ‘Title’, then, ‘Abstract’ but with little success. Selecting ‘No Field’ proved more successful in yielding results for this review.

Inclusion and Exclusion Criteria

Table 1.2 lists the inclusion and exclusion criteria used.

The timeframe was set at 2000 – 2015. This enables an up-to-date view of the literature. Prior to 2000 the research conducted was rather scant (Read et al. 2005; Manning and Stickley 2009). This is also timely given the recent attention by the media and public interest in child

abuse, including cases such as Peter Connelly 'baby P' (LSCB 2009: Serious Case Review) and Daniel Pelka (CSCB 2013: Serious Case Review). Also, the ongoing victim impact reported in the wake of Jimmy Savile sexual abuse scandal (Gray and Watt 2013). HMIC (2015) have recently published a report on child protection and alterations to the role of police in keeping children safe. Yet there appears no apparent shift in the health service in dealing with childhood trauma and the consequence in adulthood (Hanning and Gallagher 2014).

With regards to age, studies included participants reporting childhood trauma experienced before age 18 years old, the lawful age of adulthood in the United Kingdom (UK) (NSPCC 2015). There are very few studies conducted in the UK and so a wider search is required. A similarity in cultural values and social norms is necessary for a more homogeneous body of research to explore (May 2011). To achieve this, the range of countries for inclusion consisted of developed nations from North America, Europe and Australasia. Studies from Africa, Asia and South America were excluded on the basis of cultural and social difference.

The study focuses on including research that has attempted to establish if there is or is not a relationship between childhood trauma and adult mental health problems. Clinical, treatment and service provision research and studies based on brain function considering the neurological impact of trauma are not within the remit of the current search. Neither is adult trauma of homelessness and so these will be excluded.

Intra-familial abuse was used as the principal inclusion criteria. Intra-familial abuse refers to family and close caregiver relationships such as incestuous abuse. It is abuse experienced within the immediate vicinity of kinship and ordinary life experience. The range of childhood trauma identified for inclusion are child sexual abuse (CSA), child physical abuse (CPA), child emotional abuse (CEA), neglect and witnessing domestic abuse; also, child adversity such as traumatic childhood illness and death of a parent. On the other hand, extra-familial abuse is indiscriminate by nature and excluded due to its extremely broad definition. Extra-familial abuse is defined as war trauma, institutional abuse, church-related child abuse (such as child sexual abuse uncovered in the Catholic Church) and adoption abuse and so on. With intra-familial abuse the focus is on the nature of family ties, stronger bonds and level of trust between abusers and abused relative to other forms of extra-familial abuse.

With regards to mental health problems, these were searched within DSM-V (APA 2013) and ICD-10 (2015) diagnostic terms, such as anxiety, depressive, psychotic and personality disorders. Primary research studies with full text are included. Non-primary research, abstract only and commentaries are excluded. Studies that focus on a specific presentation such as substance abuse without a psychiatric diagnosis are excluded too.

Table 1.2: Inclusion and Exclusion Criteria for Childhood Trauma and Mental Health Problems

Criteria:	Inclusion:	Exclusion:
Date	2000-2015	≤2000
Language	English Only	Non-English
Gender	Male and Female	None
Age	Child trauma up to 18 years old	Trauma over 18 years old
Geography	UK, USA, Canada, NZ, Australia, Europe	Africa, Asia (China, India etc)
Study Focus	Relationship between Childhood Trauma and Mental Health Problems	Clinical Provision Service provision Homelessness Autobiographical Memory Focus Neurological Impact
Childhood Trauma	Intra-familial Abuse Sexual Abuse Physical Abuse Emotional Abuse Neglect Divorce of Parents Witness of Domestic Abuse Traumatic Illness Traumatic Significant Death (Parent)	Extra-familial Abuse Institutional Abuse Church Abuse War Victim Adoption
Mental Health Problems	ICD-10: Anxiety Disorders Depressive Disorders Psychotic Disorders Personality Disorders	Child Mental Health Problems Substance Abuse Focus Specific Symptoms (Auditory, Dissociation)
Text Format	Full Text PDF Article Primary research	Abstract Only Non-primary research Commentary

Search Process and Outputs

The process of study selection was recorded on a ‘Preferred Reporting Item for Systematic Reviews and Meta-Analyses’ (PRISMA) flow diagram (Moher et al. 2009) (See Figure 1.1

below). In total 1603 articles were identified, of which 21 were duplicates, resulting in 1382 to be considered in line with the inclusion and exclusion criteria. Of these, 1289 were excluded as not relevant. The full text for 93 articles was reviewed and a further 70 were excluded as non-primary research such as abstract only and commentaries. This resulted in 23 studies which satisfied the review criteria. A further 29 studies were obtained from additional sources such as hard copy and grey literature searches, but 22 were considered ineligible as they did not meet the review inclusion criteria. Thus from the systematic review of the literature, 30 relevant studies were retained that focus on the relationship between childhood trauma and adult mental health problems.

Quality Assessment

In order to assess the quality of the 30 studies identified from the systematic review process, a quality assessment checklist (QAC) was developed from Caldwell et al. (2005) framework for critiquing health research. The framework can be applied to quantitative and qualitative research methodologies. Quantitative and qualitative studies were assessed separately. For each paper, each criterion was rated as fully met (Yes = 2), partially met (Partially = 1), not sufficiently met (No = 0 or not possible to assess (cannot tell = 0). Total scores (out of 36) and percentage scores were calculated for each paper.

From this quality assessment process, 5 studies were excluded on the basis that they did not reach the accepted cut off point 75%. In particular, no information was provided for the rationale for each of the excluded studies, the aim of the research or study design and ethical issues not addressed. To examine the reliability of the quality assessment ten articles were rated by a researcher independent to the present review. Inter-rater reliability was calculated using the Kappa statistic, see Appendix 1a. The results of the inter-rater analysis were Kappa = 0.7140 (substantial agreement).

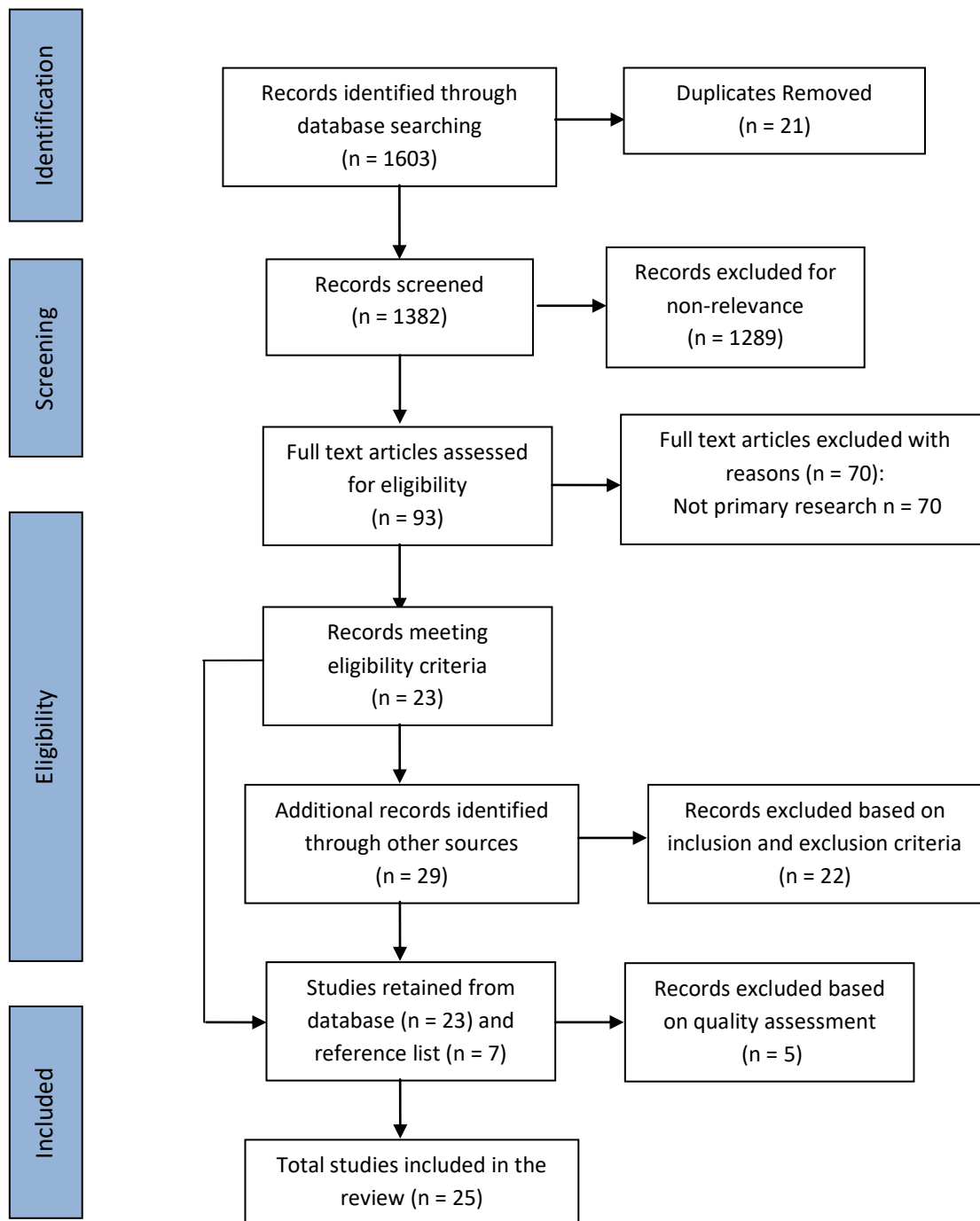


Figure 1.1: PRISMA 2009 Flow Diagram: Childhood Trauma and Mental Health Problems.

Source: Moher et al. (2009).

Characteristics of the Literature

This review yielded 25 studies in total, presented in Table 1.3. The studies are spread across three geographical areas, North America, Europe and Australasia. The country with the highest contribution is USA (11/25). The principal methodology is quantitative. Samples are largely drawn from community populations that are nationally representative and clinical populations through psychiatry and primary care. Also, some convenience samples through university populations. One study does use a sample of US high school students from aged 16 to 20 years or above. The majority of the students are adults over 18 years old who experienced childhood trauma and so the study was deemed inclusive. All studies assessed child abuse and three included adult trauma. Six studies assessed women only and 19 assessed both men and women. The combined number of participants is N = 12, 858,375.

Study Quality

None of the studies fulfilled all of the Caldwell et al. (2005) quality criteria. Across the body of literature there are variations of method, sampling, data collection measures, emphasis and findings. This creates difficulty in making direct comparisons. With regards to method, 16 studies are cross-sectional survey design, restricting any opportunity to infer causal links. Only two of these used a comparison group and both were unmatched. There are four longitudinal/prospective studies. Only three used unequivocal documented case recordings of child abuse and a matched control group. One study is phenomenological, providing insight into the lived experience of child abuse survivors and four remaining studies are good quality systematic literature reviews.

Within the cross-sectional survey designs, all relied on retrospective accounts through self-reporting measures. This can leave the research susceptible to recall bias through under or over-reporting. Sample size ranged between 102 participants from a clinical population through to 9282 from a nationally representative sample. Only two studies used randomised selection. The remaining used convenience sampling through advertising, consecutive clinical attendance and referral processes. Whilst all considered the association between childhood trauma and mental health problems, some emphasised specificity of trauma such as CSA or mental health problem, such as depression.

A range of data collection measures were used across the studies. Even though they are identified as valid and reliable the variation makes data comparison difficult. Some are trauma questionnaires and some are maltreatment rating scales. However, Pereda et al. (2009) suggests such diversity of trauma measures is common across trauma literature. One of the main measures in use for this focus of research is the Child Trauma Questionnaire (Bernstein and Fink 1998) but only three studies use this. The Composite International Diagnostic Interview (WHO 1990) is used in five studies to determine mental disorder.

Many of the studies have methodological flaws that Morrison et al. (2003) suggests is inherent in the majority of trauma research. Such flaws include, self-report, retrospective design, variation in focus and definition. Whilst this does not invalidate the findings, Morrison and colleagues advocate caution when interpreting the results of individual trauma studies.

Table 1.3: Literature Review: Childhood Trauma and Mental Health Problems								
No	Authors, Date, Location	Study Aim	Study Design	Sample Information	Methods of Data Collection	Information re: Reliability/Validity	Key Findings	Quality Rating
1	Alvarez, Roura, Oses, Foguet, Sola & Arrufat 2011 Spain	Determine the prevalence of childhood abuse and assess its clinical and prognostic impact on pts with severe mental illness.	Cross-Sectional Study	All Pts attending for a mental health consultation with schizophrenia, bipolar and schizoaffective disorder. N = 102	Structured Interview.	Validated measures: -Brief Psychotic Relative Scale, -Traumatic Life Events Q, -Distressing Event Q.	Males with schizophrenia = 20.8% CPA, 36.3% CEA, 24.8% CSA, 28.4% DV, 47.5% experienced 1 or more CT. Age of onset is 3 yrs earlier in CA and specifically CPA. 4 yrs if schizophrenia.	75%
2	Banyard, Williams & Siegel 2001 USA	Examined exposure to multiple traumas as mediators of the relationship between CSA and negative adult mental health outcomes.	Longitudinal Study	Convenience subsample of women N = 87 interviewed in the third wave of a longitudinal study of the consequences of CSA. Also, matched Comparison Group N = 87 Total N = 174	Structured Interview	Standard interview questions asked re: CSA and adult sexual assault. -Adapted National Women's Study questions for Traumatic Life Experience. Validated measures included: -Trauma Symptom Inventory. -Conflict Tactics Scale	CSA victims reported a lifetime history of more exposure to traumas and higher levels of mental health symptoms. M = 12.05% depression M = 11.57% anxiety M = 10.27% impaired self-reference. CSA = exposure to CT's.	75%
3	Bifulco, Moran, Baines, Bunn & Stanford 2002 UK	Investigate the association of childhood psychological abuse with depression and suicidal behaviours across the life course.	Cross-Sectional Study	Community-Based study on women from primary care. The sample previously identified for vulnerability to lifetime depression. N = 204	Structured and Semi-Structured Interview	Validated measures: -Present state examination' -Schedule for Clinical Assessment in Neuropsychiatry, -Childhood Experience of Care and Abuse, -Parental Bonding Instrument.	CEA almost totally overlapped with neglect and antipathy and almost always accompanied by other CT. 59% women with CEA were depressed in yr prior. All forms of CT significantly related to MDD.	75%
4	Chen, Murad, Paras, Colbenson, Sattler, Goranson, Elamin, Seime, Shinozaki, Prokop & Zirakzadeh 2010 USA	Systematically assess the evidence for an association between sexual abuse and lifetime diagnosis of psychiatric disorders.	Systematic Review and Meta-Analysis	The search yielded 37 eligible studies. N = 3,162,318	9 computer data bases	Quality Assessment via Newcastle-Ottawa quality assessment scale.	Association between CSA & lifetime diagnosis of anxiety, depression, eating disorder, PTSD, sleep disorder, suicide attempts. Association persisted regardless of gender or age abuse occurred. No association found with CSA and schizophrenia.	75%
5	Flett, Kazantzis, Long, MacDonald, Millar, Clark, Edwards & Petrik 2012 New Zealand	Understand long-term impact of CSA. Examined association between women's experience of abuse, health symptoms, and psychological distress in adulthood.	Cross-Sectional Survey	Women adults selected based on an area probability sample from 14 districts of New Zealand. N = 961	Structured Interview	Validated measures: -Traumatic Stress Schedule -Mental Health Inventory -Pennebaker Inventory of Limbic Languidness -Checklist of Serious Medical Conditions	CSA = higher rates of physical symptoms & psychological distress. More likely to report more stressful events.	75%

No	Authors, Date, Location	Study Aim	Study Design	Sample Information	Methods of Data Collection	Information re: Reliability/Validity	Key Findings	Quality Rating
6	Gibb, Chelminski & Zimmerman. 2007 USA	We hypothesized that adult psychiatric outpatients' reports of childhood emotional abuse would exhibit a specific relationship with diagnoses of depression.	Cross-Sectional Retrospective Design	Psychiatric outpatients who were evaluated as part of another project. 60.3% women. N = 857	Structured Interview	3 month rater training. Validated measures included: -Structured Clinical Interview for DSM-IV, -Childhood Trauma Questionnaire.	Major depression strongly related to CEA. Anxiety to CSA & CPA. PTSD reported higher CEA, CSA & CPA than MDD. Women reported significantly more CEA, CSA than men.	75%
7	Green, McLaughlin, Berglund, Gruber, Sampson, Zaslavsky & Kessler. 2010 USA	Examine the joint associations of 12 Childhood Adversities with first onset of DSM-IV disorders.	Cross-Sectional Community Survey	Nationally representative sample. N = 9282	Structured Interview	Validated measures: -National Comorbidity Survey -Composite International Diagnostic Interview.	53.4% reported 1 CA. Divorce = 17.5%, DV = 14.0% Economic adversity 10.3%. Multiple CAs norm. Mean = 3.2 CAs 95.1% of neglect had more than 1 CA and 87.6% CPA had more than 1 CA.	80%
8	Kaplow & Widom 2007 USA	Children who are maltreated earlier in life are at greater risk for poor psychological functioning in adulthood than those maltreated later in life.	A prospective cohort design study.	Documented cases of physical and sexual abuse and neglect prior to age 12 were followed up and assessed in adulthood. N = 496	1. Examine records. 2. Structured and semi-structured Interview at 22 yrs and 29 yrs. 3. Structured Interview approx' 40 yrs old.	Validated measures: -NIMH Diagnostic Interview Schedule, -Centre for Epidemiological Studies- Depression Scale, -Beck Anxiety Inventory,	Child older at onset of CA at higher risk of ASPD. Younger onset reported higher levels of depression & anxiety at 40 yrs. Age of onset of CA has significant impact into adulthood.	85%
9	Kristensen & Lau 2007 Denmark	Investigate whether female patients with a history of CSA differs sociodemographically & psychologically from the general female population & investigate predictors of violence and penetration connected to intrafamilial CSA.	Cross-Sectional Survey	Danish-speaking women over the age of 18, who were referred for treatment in an incest group (IG). N = 385 Also, demographically matched Comparison group N = 1875	Structured Interview	No specific evidence of measures used.	39% had attempted suicide & half of these made more than 1. 62% had received psychiatric treatment. 21% previous admission to MH Unit. 36.4% = PD. 23.0% = Adjustment 14.4% = Anxiety states 13.6% = Affective illness	75%
10	MacMillan, Fleming, Streiner, Lin, Boyle, Jamieson, Duku, Walsh, Wong & Beadslee 2001 Canada	Assess lifetime psychopathology in general population sample & compare rates of 5 psychiatric disorder categories between CSA or CPA & those who did not.	Cross-Sectional Survey	Probability sample of 15-64 yr olds. Taken from the Ontario health survey. N = 7, 016	Structured Interview	Validated measures: - Composite International Diagnostic Interview, -Child Maltreatment History Self-Report	Lifetime prevalence of a major psychiatric disorder increased by CPA or CSA. CPA or CSA statistically significant for all disorders for females. Men with CSA had higher rates of psych disorder.	75%

No	Authors, Date, Location	Study Aim	Study Design	Sample Information	Methods of Data Collection	Information re: Reliability/Validity	Key Findings	Quality Rating
11	Maniglio 2010 Italy	A systematic review of the several reviews that investigate the literature on the role CSA plays in the etiology of depression.	Systematic Literature Review of Reviews	Search yielded 4 reviews. N = 60,000 from 160 studies.	7 computer data bases searched and a manual hand search from reference lists.	Valid systematic review guidelines. Validity of each study considered through strict inclusion criteria and a quality assessment.	There is evidence that child sexual abuse is a significant, although general and nonspecific, risk factor for depression.	85%
12	Maniglio 2012 Italy	A systematic review of the several reviews that investigate the literature on the role CSA plays in the etiology of anxiety.	Systematic Literature Review of Reviews	Search yielded 4 meta-analyses. N = 3, 214,482 from 171 studies.	7 computer data bases searched and a manual hand search from reference lists.	Valid systematic review guidelines. Validity of each study considered through strict inclusion criteria and a quality assessment.	There is evidence that CSA is significant, although general and non-specific, risk factor for anxiety disorders, especially PTSD, regardless of gender of victim and severity of CSA.	85%
13	Maniglio 2013 Italy	A systematic review of the impact of CSA on all clinical phenomena that occur after the onset of bipolar disorder.	Systematic Literature Review	Search yielded 18 studies. N = 2996	5 computer data bases searched and a manual hand search from reference lists.	Valid systematic review guidelines. Validity of each study considered through strict inclusion criteria and a quality assessment.	There is evidence that CSA was strongly (and perhaps directly) associated with PTSD. Association between CSA and other clinical variables concerning the course of bipolar disorder, evidence was scant or conflicting.	85%
14	Molnar, Buka & Kessler 2001 USA	Examined the relationship between CSA and subsequent onset of psychiatric disorders, accounting for other childhood adversities, CSA type and chronicity of the abuse.	Cross-Sectional Community Survey	Nationally representative sample. N = 5877	Structured Interview	Validated measures: - Composite International Diagnostic Interview, -National Comorbidity Survey.	Significant association between CSA & onset of 14 mood, anxiety and substance disorders among women and 5 among men. Depression & CA = 39.3% women, 30.3% men. Any disorder & CA: women = 78.0%, men = 82.2%.	75%
15	Moskvina, Farmer, Swainson, O'Leary, Gunasinghe, Owen, Craddock, McGuffin & Korszun 2007 UK	The relationship of CT to age of onset (AO) of depression, personality traits and expression of symptom dimension.	Cross-Sectional Survey	Adults with recurrent depression from two sites in UK. N = 324	Structured Interview	Validated measures: -Schedule for Clinical Assessment in Neuropsychiatry (SCAN), -Childhood Trauma Questionnaire, -Eysenck Personality Questionnaire, Beck Depression Inventory Also completed: SCAN training Inter-rater reliability sessions	CEA = 50.6%, Physical neglect = 60.8% - Consistent for both men and women. CPA = Men = 32.6% CPA = Women = 20.0% Mean AO overall = 15.9 yrs in association with CT severity. CEA and physical neglect most significant predictor for AO (P < .008).	75%

No	Authors, Date, Location	Study Aim	Study Design	Sample Information	Methods of Data Collection	Information re: Reliability/Validity	Key Findings	Quality Rating
16	Perales, Olaya, Fernandez, Alonso, Vilaqut, Forero, San, Alda & Haro. 2013 Spain	Study the prevalence of a wide variety of CAs, as well as their relationship to the onset of mental disorders.	Cross-Sectional Survey	A nationally representative sample of the Spanish adult population. N = 2,121.	Structured Interview	Validated measures: -Composite International Diagnostic Interview, -ESEMeD-Spain Interview, -Family History Research Diagnostic Criteria interview, -Conflict Tactics Scale.	20.6 % reported at least 1 CA and 24 % of them more than one CA. CA & all disorders = 12.6% CA % mood = 10.8% CA & anxiety = 5.8% CA & substance = 27.0% CA & externalising = 29.7% 8/10 CAs significantly associated with any mental disorder onset.	75%
17	Pirkola, Isometsä, Aro, Kestilä, Hämäläinen, Veijola, Kiviruusu, & Lönnqvist. 2005 Finland	Investigate what and how childhood adverse environmental factors associate with adulthood mental disorders, and to explore possible differences between males and females in this regard.	Retrospective Survey design	A nationally representative sample of the Finnish adult population. N = 4076	Telephone & Structured interview	Validated measures: - Composite International Diagnostic Interview, -Beck Depression Inventory, -General Health Questionnaire.	60% of adults reporting at least 1 CA and 17% had a current mental disorder. CA = Parental MHP, alcohol problems, bullied at school & family discord more typical for depressive disorders, earlier onset & more among females.	75%
18	Putnam, Harris & Putnam. 2013 USA	This study uses the National Comorbidity Survey-Replication sample to investigate cumulative impact of 8 childhood adversities on adult psychopathology.	Cross-sectional Survey	Nationally representative adult sample. (N = 5,692)	Structured Interview	Validated measures: -National Comorbidity Survey-replication	Seven of 8 CAs significantly associated with complex adult psychopathology. Cumulative risk score = 1 Ca = 1 diagnosis, through to 4+ = over 3 diagnoses. No of CA is protective.	85%
19	Saleptsi, Bichescu, Rockstroh, Neuner, Schauer, Studer, Hoffmann & Elbert 2004 Germany	Explores the relationship between psychiatric diagnoses and positive and negative life events during childhood and adulthood in psychiatric samples.	Cross-sectional survey	Psychiatric patients from 4 psychiatric hospitals across 2 cultural settings. N = 192 Also, unmatched control group. N = 63	Structured Interview	Validated measures: -ICD-10, -Traumatic Antecedents Questionnaire.	CEA = higher in PD and Schizophrenia. CPA = Higher in PD and schizophrenia. CSA = higher in schizophrenia, affective disorders & alcohol abuse. CSA occurred later in development periods and mainly female.	75%
20	Schilling, Asepline & Gore 2008 USA	Explores cumulative Childhood Adversity on young adult mental health in two waves.	Prospective Cohort Study	Probability sample of high school seniors from 9 schools in Boston. N = 1578	Telephone & Structured interview	Validated measures: -Centre for Epidemiological Studies' Depression Scale -Qs similar to National Comorbidity Survey.	Total cumulative CAs significantly predicts depressive symptoms, anti-social behaviour & drug use. CAs damage MH as they accumulate over a lifetime.	80%

No	Authors, Date, Location	Study Aim	Study Design	Sample Information	Methods of Data Collection	Information re: Reliability/Validity	Key Findings	Quality Rating
21	Sesar, Šimić & Barišić 2010 Bosnia & Herzegovina	To retrospectively analyze the rate of multi-type abuse in childhood and the effects of childhood abuse & coping strategies on the psychological adaptation of young adults.	Cross-sectional survey	A convenience sample of university students. N = 233	Structured Interview	Validated measures: -Child Maltreatment Scales for Adults, -Trauma Symptom Checklist, -Coping Inventory for Stressful Situations	74% = multi-type abuse 5% = all types of abuse Significant association between all types of abuse Exposure to CSA & coping strategy type predicted GAD/MDD. Highest = CEA/CPA together	75%
22	Sigurdardottir & Halldorsdottir 2013 Iceland	The purpose of this study was to examine the consequences of childhood sexual abuse for women's health and well-being.	Phenomenological	Women with a history of CSA. Purposive sample from two education and counselling centres. N = 7	Semi-structured Interview x 2	Validity discussed: Vancouver school research process. Member checking Researcher triangulation	All suffering multiple physical and psychological symptoms: five have fibromyalgia; all have suffering chronic and widespread pain. All dealing with depression & difficulty trusting others.	85%
23	Spertus, Yehunda, Wong, Halligan & Seremetis 2003 USA	To examine whether CEA and emotional neglect predict psychological and somatic symptoms, and lifetime trauma exposure & examine the strength of relationship.	Cross-sectional survey	Convenience sample of women presenting in primary practice. N = 205	Self-completed questionnaire	Validated measures: -Childhood Trauma Q, -Trauma History Q, -Symptom Checklist-90R, -Revised Civilian Mississippi Scale for PTSD.	CPA = 12% - CSA = 21% CEA = 42% - CEN = 43% CEA & CEN predict trauma. CEA & CEN significant predictor of anxiety, somatoform, MDD & PTSD.	80%
24	Waite & Shewokis. 2012 USA	A study that examined the relationship between Adverse Childhood Experience (ACEs) and self-reported depression among low-income ethnic minority in an urban setting.	Cross-sectional Survey	Adult patients at a nurse managed healthcare centre. (N = 801)	Self-completed questionnaires	Validated measures: CDC approved: -Family Health History -Health Appraisal Questionnaire	Significance for 7/10 ACEs & self-reported MDD. Clinical significance for 4/10. Statistical significance was found for most ACEs.	80%
25	Widom, DuMont & Czaja 2007 USA	To determine whether abused and neglected children were at elevated risk of MDD and psychiatric comorbidity compared to control group.	Prospective Longitudinal Cohort Study	Adult survivors found through court records of child abuse cases. Data used from second phase of the study to find sample. N = 676 Matched control group. N = 520 Total N = 1196	Structured and Semi-Structured Interview	Validated measures: - Diagnostic Interview Schedule version III Revised.	25% CA group met criteria for lifetime MDD. CPA & multiple CA at elevated risk of MDD. Neglect, CSA & multiple CA more symptoms & episodes of MDD. 91.3% with MDD met criteria for at least 1 CA. 86.4% abused or neglected with MDD met criteria for PTSD, GAD, Drug abuse.	75%

Key Findings

The studies in this review consider the association between childhood trauma and adult mental health problems. Three main themes were identified (Carnwell and Daly 2001), including association between childhood trauma and mental health problems, patterns identified and forms in which it is experienced.

Association between Childhood Trauma and Mental Health Problems

The association will be discussed in terms of two key issues: nature of association to determine the type of connection and strength of association to consider the potency of such a connection.

Nature of Association

All studies found a statistically significant association between childhood trauma and adult mental health problems. Individuals with a psychiatric diagnosis during adulthood are significantly more likely to have experienced at least one type of childhood abuse (47.5%) (Alvarez et al. 2011). For example, studies that surveyed clinical populations found there is an average reporting of CSA in 31% of females and 18% of males (Alvarez et al. 2011). However, without a comparison group to assess through the same methods, it is not possible to infer association because child abuse occurs in a minority of the general population (Bendall et al. 2007). For instance, in community populations women report CSA at a lower average of 13% (Flett et al. 2012) and men a lower average of 3.5% (MacMillan et al. 2001). One such study conducted by Saleptsi et al. (2004), did use a healthy control group for comparison and found similar results to Alvarez and colleagues.

The research suggests that CSA, CEA, and CPA, are the most prominent traumas associated with poor mental health outcomes. They are also the most researched, with CSA a focus of specificity in 9 studies. In a systematic literature review on CSA and adult symptomatology, Maniglio (2010) found that survivors of CSA are at significantly high risk of poor adult mental health problems. This is also supported in a longitudinal study of 174 participants with documented CSA by Banyard et al. (2001), who found a bivariate association with all adult mental health outcomes, $p < 0.001$. Also, a nationally representative study of 2121 participants

by Perales et al. (2013) determined that CSA has the highest association with mental health outcome of all traumas (odds ratio (OR) 7.37; 95% confidence interval (CI), 5.21-10.43).

The presence of CEA is also significant. In research focused on clinical populations CEA has a significant association with mental disorders (Gibb et al. 2007). Moskvina et al. (2007) identified total childhood trauma was a significant ($P < 0.008$) predictor of depression, mostly accounted for by CEA ($P < 0.019$). In Saleptsi et al. (2004) CEA was more frequently reported by the clinical sample controls [$F(4,194) = 7.0, P < 0.001$]. Also, in Spertus et al. (2003) study, 46/205 (22.5%) women reported moderate to severe CEA. This was also true of community studies such as Bifulco et al. (2002) who found a 'dose-response' effect with major depressive disorder (MDD) at 83% marked to 55% mild level of CEA, ($p < 0.002$). However, not all found similar results. For example, although Alvarez et al. (2011) found that women had twice the probability as men of suffering CEA, it was without statistical significance (OR, 2.2; $p < 0.06$). Their data shows lower prevalence overall than other studies, which may be explained by the strict definitions of Traumatic Life Events Questionnaire (TLEQ) (Kubany and Haynes 2001).

CPA was present in the literature but did not reach the prominence or significance of CSA or CEA unless the population is clinical and includes males. Then, it is identified as having a strong association with severe mental disorder (Moskvina et al. 2007). In Saleptsi et al. (2004) post-hoc comparisons revealed higher rates of CPA reports among individuals with alcohol-related disorders ($P < 0.01$) and schizophrenic disorders ($P < 0.05$). Clinical samples were drawn from different diagnostic categories, so findings cannot be generalised, even within the same population. However, Perales et al. (2013) also found CPA associated with substance disorders (OR = 3.6, 95% CI, 1.2-10.5).

Strength of Association

The strength of the association between childhood trauma and mental health problems is important to determine. In a predictive sense, Green et al. (2010) nationally representative study of 9282 participants, identify childhood trauma as explaining an average 32.4% of all mental disorders. This was calculated through the population-attributable risk proportion of lifetime disorder associated with childhood adversity by life stage. It is even higher when explaining childhood-onset disorders (44.6%) and remains significant through to adolescence 32.0% and to adulthood 28.6% (Green et al. 2010). The strength of association is further

endorsed by Perales et al. (2013) who found eight out of ten childhood traumas significantly associated with any mental disorder ($p < 0.05$), 2-tailed. In the multivariate model only the number of traumas was taken into account; the higher the number of traumas, the stronger the association with mental disorder ($p < 0.001$).

As well as the most prominent association, CSA is found to have the strongest association too. In a systematic literature review and meta-analysis of CSA and psychiatric disorders, Chen et al. (2010) found the strength of association persists regardless of gender of the abused or the age the abuse occurred. Chen and colleagues found a statistical significant association between CSA and anxiety (OR, 3.09; 95% CI, 2.43-3.94) or depressions (OR, 2.66; 95% CI, 2.14-3.30). This review had a total combined sample of $n = 3,162,318$ from 37 eligible studies (Chen et al. 2010). Similarly, Maniglio (2010; 2012; 2013) provides three systematic literature reviews with a combined sample of $n = 3,276,478$ from 349 eligible studies and determined that all group outcomes irrespective of population are significant in strength of association. He also highlighted that clinical populations generate larger effect size estimates, compared to subject samples drawn from community, student, or other populations.

Patterns in the Association between Childhood Trauma and Mental Health Problems

The patterns in the association will be discussed in terms of four key issues. Firstly, pattern of association explores the different ways the association presents. Secondly, the onset of trauma considers the timeframe in which childhood trauma first occurs. Thirdly, the nature of abuser discusses the main perpetrators of childhood trauma. Finally, onset of mental health problems identifies the timeframe in which such difficulties first appear.

Pattern of Association

One of the major patterns identified in the literature are factors that increase risk. In Banyard et al. (2001) longitudinal study, they found that the greater the number of traumas, the greater the odds of psychopathology. Indeed, individuals with greater number of traumas are also at risk of increased symptoms and increased episodes of mental disorder, $p < 0.001$ (Perales et al. 2013). In addition, Putnam et al. (2013) examined a nationally representative sample of $n = 5692$ exploring cumulative impact of eight childhood adversities on adult psychopathology. Seven of the 8 adversities were significantly associated with complex adult

psychopathology and individuals with 4 or more adversities had an OR of 7.3, 95% CI [4.7, 11.7] for 4 disorder categories. Outcomes were empirically examined from three perspectives, including number of diagnoses, disorder categories and co-presence of externalizing and internalizing disorders. A similar study by Molnar et al. (2001) found that five or more traumas increase the odds of certain psychiatric diagnoses by 8 times. Schilling et al. (2008) suggest increased odds are based on severity, rather than number.

It is not only the cumulative effect and number of traumas that are significant to poor mental health outcomes. Maniglio (2012) systematic literature review yielding 4 meta-analyses with 171 studies, found that the pattern of association between CSA and adult mental disorder was influenced by further specific factors. Rather than nature of force, penetration, severity, duration, and/or frequency of trauma, he determined that trauma type, age of onset and by whom the trauma is perpetrated is important. This also applies to CEA, CPA and neglect, particularly when intra-familial in nature. A key consideration is the higher significance child abuse (e.g., CSA) has as a predictive factor for lifetime risk of mental disorder compared to other traumatic childhood events (e.g., parental divorce). For example, see Green et al. (2010) with OR, 2.1 [95% CI, 1.6-2.6]; and Widom et al. (2007) with OR, 1.51; [95% CI, 1.06-2.14]; ($P < 0.05$).

Studies with matched control groups (see Banyard et al. 2001; Kaplow and Widom 2007; Widom et al. 2007) and Saleptsi et al. (2004) with an unmatched healthy control group determined that individuals with few or no childhood trauma reported significantly less or no lifetime mental disorders. This suggests that absence of trauma in childhood is associated with better adult mental health outcomes. However, it is necessary to consider that a child with few traumas may not be comparable to a child with one abuse experience. As discussed above, the nature of the trauma is important.

Onset of Trauma

Onset of trauma data is limited but does identify two distinct pathways. It appears that early or late childhood onset is significant in the associated course of adult mental disorder. Some subjects report experiencing child abuse in early infancy, with an average age of onset at 6.4 years old (Kristensen and Lau 2007; Moskvina et al. 2007). Others report child abuse taking place in later developmental stages following puberty (Saleptsi et al. 2004). In the first addition

prospective study to examine whether age of onset of child maltreatment predicts risk to adult mental disorder, Kaplow and Widom (2007) used documented and substantiated cases to identify two different trajectories. Individuals abused earlier in life (before 12 years old) demonstrate higher levels of internalising mental health problems (e.g, depression) in adulthood. Those older (over 12 years) at the time of child abuse demonstrate higher levels of externalising mental health problems (e.g, substance abuse). They controlled for the effects of current age as well as any reports of maltreatment so that the age of onset could be assessed as a unique predictor of later psychological problems. Other unmeasured variables may also be responsible for age of onset and psychological functioning, such as severity and identity of perpetrator.

Nature of Abuser

The nature of the abuser was discussed in 9 studies with regards to CSA specifically. Research found that the most likely to commit CSA are nuclear family members. Kristensen and Lau (2007) found up to 50% reported the biological father as perpetrator, then step-father or brother as the next most common perpetrator. Also, over 80% reported intra-familial CSA from broader family members such as uncles and grandfathers. Up to 20% reported being abused by a family member and another, unrelated perpetrator (Kristensen and Lau 2007). Flett et al. (2012) found the most common response was to choose 'unspecified' (45%) and not identify the perpetrator. This may depend on the option being available in the questionnaire, but it also allows an individual to withhold their relationship to the perpetrator.

The literature also considered how CSA is perpetrated to be a significant influence on subsequent mental health problems in adulthood. As a mainly intra-familial experience, personal boundaries are broken between the perpetrator and victim. For instance, sexual penetration takes place significantly more often if the perpetrator is biologically intra-familial than if the perpetrator is a step-father, foster father or adoptive father (Kristensen and Lau 2007). In addition, Banyard et al. (2001) found CPA was identified by up to 68.8% who experienced the use of force in association with CSA. Also, duration of intra-familial abuse generally occurs for more than a two year period (Kristensen and Lau 2007). This suggests the influence of incest is most damaging. It breaks personal boundaries and occurs over a long period of childhood, which has been found to strengthen the association between CSA and mental disorder (Maniglio 2012).

Onset of Mental Health Problems

Five studies provided data on the age of onset for mental health problems. Four of the studies focused attention on this subject and one supplied information as additional data. The younger the person experiences trauma, the earlier the onset of mental health problems. This includes childhood onset. Specifically, Moskvina et al. (2007) found earliest age of onset for depression was 9.5 years old in males ($n = 4$) and 16.8 years in females ($n = 30$), with a history of severe childhood trauma. The mean age of onset for those with no trauma history was 27.9 years. Using analysis of variance, Widom et al. (2007) prospective longitudinal study also found age of onset for depression was earlier in adults with a history of child abuse (mean 18.2 years; SD, 7.6 years), compared to the control group (mean 20.8 years; SD, 6.7 years). Such findings cannot be generalized to public or psychiatric population due to specificity of diagnosis.

For individuals with a diagnosis of bipolar disorder, the onset is three years earlier. This is especially evident with people who have a history of CEA (Alvarez et al. 2011) and CSA (Maniglio 2013). The onset is even earlier if the diagnosis is schizophrenia (Alvarez et al. 2011). Alvarez and colleagues found that people with schizophrenia were diagnosed 4.1 years earlier if they had experienced any child abuse ($p < 0.015$). Perales et al. (2013) identified similar results with multivariate associations between child abuse and mental disorder. With regards to childhood onset (4-12 years) of any mental disorder, they found significant associations ($p < 0.05$) with CPA [OR, 2.8; (95% CI 1.4-5.6)], CSA [OR, 12.4, (95% CI 3.1-48.9)] and parental mental illness [OR, 6.7; (95% CI 3.5-13.0)]. These results identify significant early onset, despite a recognised time lag between first symptoms and diagnosis (Leverich et al. 2002).

Forms of Childhood Trauma and Mental Health Problems Experienced

Experiences are discussed in terms of five key areas. Firstly, types of childhood trauma will consider variations of experience. Secondly, multiple trauma type examines the nature of cumulative experience. Thirdly, types of mental health problem explore variations in diagnosis. The fourth area identifies severity of mental health problem. Finally, the socio-demographic influence of gender is considered.

Types of Childhood Trauma

CSA is the main childhood trauma explored by far. It is represented in the results of 24 of the 25 studies reviewed and the specific research focus for 9 studies. CSA is also the focus of Chen et al. (2010) literature review and meta-analysis of 37 studies. This research shows that CSA has the highest association with poor adult health outcomes of all traumas. This includes prevalence of any lifetime mental health problem (Chen et al. 2010) and higher rates of physical health problems (Flett et al. 2012).

CPA is the next highest abuse represented in fifteen studies. It featured across these studies as one of the child abuses explored, as no study looked at CPA specifically. Results suggest that CPA is associated with increased risk of adult psychopathology, but in particular, severe mental disorder. For example, Alvarez et al. (2011) found that on average, one in five individuals with schizophrenia or bipolar disorder report a history of CPA. Putnam et al. (2013) surveyed a community sample size of $n = 5692$ and identified the strongest association with CPA is with the complex adult psychopathology of co-morbidity (a combination of at least two mental disorders). In addition, Perales et al. (2013) found CPA was the only adversity associated with the first onset of every disorder considered in their study; at the significant level ($p < 0.05$, 2-tailed). Disorders include mood, anxiety, substance and externalising, based on CIDI (Kessler and Ustun 2004) criteria. Unfortunately these cluster terms do not differentiate MDD from Dysthymic disorder, or PTSD and agoraphobia.

The presence of CEA is evident in the association of various lifetime mental health problems in nine studies. For instance, Gibb et al. (2007) study of a large sample of psychiatric outpatients identified CEA as significantly associated with MDD ($P < 0.009$) and the presence of 'any anxiety disorder' (OR, 1.06; 95% CI, 1.02-1.10; $P < 0.002$). This is also inclusive of both chronic and recurrent presentations of depression (Bifulco et al. 2002, Moskvina et al. (2007). Severity of CEA was examined specifically by Bifulco et al. (2002) who found clear evidence of a 'dose-response' effect in the association of MDD with rates from 83% at marked and 55% at mild levels. Even with a combination of CEA, CSA and CPA too; CEA is the most prevalent abuse experience associated with MDD. CEA also has a significant association with a range of further psychiatric diagnoses, including anxiety disorders (Spertus et al. 2003), personality disorders and schizophrenia (Saleptsi et al. 2004).

Childhood neglect was examined in nine studies. No study considered neglect specifically, but rather as one of the child abuses. In some studies, neglect is separated between child emotional neglect (CEN) and child physical neglect (CPN). Where they are separated, no explanation or definition is offered. Research suggests both have a significant relationship with adult mental health. For example, Moskvina et al. (2007) found the most common trauma reported in their clinical sample of $n = 324$ was CPN (overall sample = 60.8%). Moskvina and colleagues used the child trauma questionnaire (Bernstein and Fink 1998) where a specific domain for CPN is present. No other study extrapolated similar data. In addition, CEN was found to have a strong relationship with CEA, in predicting adult emotional and somatic distress (Spertus et al. 2003). Although this was the specific focus of their study, the strength was apparent even when partialling out the variance accounted for by CPA, CSA and lifetime trauma exposure [F change (2,199) = 6.84, $p < 0.005$].

Domestic abuse is considered in the findings of eight studies. In Green et al. (2010) community study, they found statistical significance of ($P < 0.05$, 2-sided) for multivariate associations between family violence and all disorders considered, with OR, 1.7; 95% CI, 1.5-2.0. Similar findings were identified by Perales et al. (2013) who also found the experience of family violence had a higher mean of childhood adversities [$M = 3.3$ (SE 0.3)]. However, in a clinical population, Alvarez et al. (2011) found the odds ratio for witnessing domestic violence and psychiatric diagnosis was without statistical significance. This may highlight a disparity of meaning and definition in data collection.

Economic adversity was included in the research findings of four studies. Results were mixed, with Green et al. (2010) identifying a bivariate association between economic adversity and first onset mental disorder, [OR, 1.3 (95% CI, 1.2-1.4), $p < 0.05$, 2-tailed. Perales et al. (2013) found a multivariate association between economic adversity and mental disorders diagnosed at 13-24 years [OR = 3.6 (95% CI 1.6-8.2)], but not other ages. Two further studies found a gender split. For example, Putnam et al. (2013) identified economic adversity in childhood as the most frequent multiplicative childhood adversity for men. Also, Pirkola et al. (2005) logistic model associated financial hardship at home with all mental disorders for men after adjustment. All four studies were national surveys with sample size between $N = 4076$ and 9282.

The remaining types of childhood trauma did not have statistical significance for an association with poor adult mental health outcomes. For example, parental substance abuse is featured across seven studies, but does not hold the significance of child abuse discussed earlier. The remainder of traumas range across 20% or less of the body of literature. As an example, although death of a parent is only featured in two studies, in one study it is reported as the most common childhood trauma at 11.3% compared to CPA at 3.0% (Perales et al. 2013). Other traumas identified include parental divorce, parental mental illness, and parental criminality.

Multiple Trauma Type

The impact of multiple traumas on the mental health of participants is significant. Of eleven studies that analysed its influence, four made it the focus of their research (Banyard et al. 2001; Gibb et al. 2007; Moskvina et al. 2007; Sesar et al. 2010) and a further 7 embedded it into their results. The range of reported multi-type trauma was between 55.6% in a clinical population reporting two or more traumas (Moskvina et al. 2007) and 74% in a student population considering more than one trauma (Sesar et al. 2010). Both studies focused on child abuse such as CSA, CPA, CEA and neglect. A minimum of three types was reported in up to 47% and at least four by 18.5% in both clinical and community samples. Five types of moderate to severe trauma were experienced by up to 6.5% of subjects (Moskvina et al. 2007, Sesar et al. 2010). Green et al. (2010) determined the mean number of traumas in childhood to be $M = 3.2$ ($SE 0.0$) in participants with more than one trauma. This was based on 12 dichotomous childhood adversities drawn from literature.

Multiple traumas are the norm for a number of trauma types, but especially child abuse: CEA, CPA and CSA (Gibb et al. 2007). Research by Sesar et al. (2010) found that 74% of a large student sample reported experiencing multi-type childhood abuse. The most common co-occurring traumas reported in a clinical population are CEA and neglect at 36.7%, CEA and CPA at 17% and, CEA, CPA and neglect experienced by 13% (Moskvina et al. 2007). Indeed, CEA is almost always accompanied by other forms of childhood trauma (Bifulco et al. 2002, Gibb et al. 2007, Spertus et al. 2003). Other common combinations include CPA with CSA in women exposed to penetration or more than one abuser (Kristensen and Lau 2007). In addition, individuals who experience higher total cumulative childhood trauma will have disproportionately poorer adult mental health (Schilling et al. 2008).

Types of Mental Health Problem

There are 3 main ICD-10 (2015) diagnostic categories that have a higher prevalence in the literature than others. These are depressive disorders, anxiety disorders and substance abuse. Depressive or mood disorders are a collective term used in the literature to describe diagnoses such as depression, mood disorder, major depressive disorder (MDD) and affective disorder. They have the highest presence in this review due to the specificity of enquiry in twenty-one studies. Similarly, anxiety disorders feature in 15 and include generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), and post-traumatic stress disorder (PTSD); although 4 studies identify PTSD separately from anxiety disorder. Finally, substance abuse incorporating alcohol or drug abuse has results recorded in nine studies reviewed.

In studies focused on psychiatric populations, diagnoses of schizophrenia, bipolar disorder and personality disorder are represented (Alvarez et al. 2011; Kristensen and Lau 2007; Saleptsi et al. 2004; Maniglio 2013). However, they do not feature in the community studies reviewed here. In Chen et al. (2010) systematic review and meta-analysis of sexual abuse and lifetime diagnosis of psychiatric disorders, schizophrenia is present in only three of the 37 studies reviewed and personality disorder is not listed. This is an interesting omission given that the review focused on lifetime psychiatric disorder and personality disorder was not excluded. Conversely, research conducted by Kristensen and Lau (2007) with a psychiatric sample of women with a history of CSA, found personality disorder was the primary diagnosis at 36.4% of subjects. This highlights two areas of concern. One is possible diagnostic bias and the second is population bias.

Severity of Mental Health Problem

A history of childhood trauma appears to modify the progression of the mental health problem. Based on clinically documented data, individuals from psychiatric populations with a history of child abuse experience earlier onset and worse episodes of psychosis, a higher number of suicide attempts and higher number of hospital admissions, compared to those with no history of childhood trauma (Alvarez et al. 2011; Kristensen and Lau 2007). Mental health symptoms are also increased (Banyard et al. 2001), along with episodes of illness and diagnostic comorbidity (Putman et al. 2013). In addition, Widom et al. (2007) found need for higher levels of psychiatric treatment access.

In Maniglio (2013) systematic literature review of CSA and a diagnosis of bipolar disorder, found at a univariate level, a significant association with a number of clinical variables that increase severity of mental disorder. They include severity of manic and depressive episodes, rapid cycling, lifetime psychotic symptoms, lifetime substance abuse, lifetime PTSD, lifetime panic disorder, and comorbid personality disorders. At a multivariate level, he found a history of CSA was independently associated with lifetime PTSD, longer duration bipolar and lifetime conduct disorder.

Socio-Demographic Factors: Gender

Socio-demographic data varied across the studies depending on focus, making comparison difficult. However, one major demographic considered across the literature is gender. Ten studies focus specifically on the experience of women or separate results by gender with regards to childhood trauma and adult mental health problems. There are gender-differences in the results of all ten studies and the distribution of psychiatric diagnoses appears gender-related too. For example, women experience more child abuse than men and are at increased risk of adult mental health problems. Pirkola et al. (2005) identified several possible reasons. They believe women have a stronger vulnerability to traumatic events due to gender-specific trauma, gender transmission, gender role, genetic nature, increased psychological mindedness and so on. Gender differences in childhood trauma and mental health problems will now be explored.

Differences in Nature of Childhood Trauma Experienced: Women are more likely to suffer child abuse than men, except for CPA. The research suggests women endure higher levels of abuse, suffer multiple types of abuse, have a younger average age of first abuse experience and increased risk of poor adult outcome compared to men (Molnar et al. 2001; Moskvina et al. 2007; Putnam et al. 2013). Kristensen and Lau (2007) found the age of the first instance of intra-familial CSA was $M = 6.8$, $SD 3.4$ years and age it ceased was $M = 13.0$, $SD 4.0$ years. Median duration of intra-familial CSA was 6.2 years compared to 3.9 years for extra-familial ($P < 0.001$). Only 11% of intra-familial CSA continued for less than 2 years (Kristensen and Lau 2007). Evidence suggests CSA is more often experienced by women (Saleptsi et al. 2004, Gibb et al. 2007). Women reporting CSA in clinical populations is nearly double that of men (Alvarez et al. 2011) and in community populations, over 3 times more (MacMillan et al. 2001).

The effect of reported childhood trauma seems to be stronger among women. This is measured by the number of significant associations with mental disorder and the level of significance (Pirkola et al. 2005). An example is women who experience CSA in combination with domestic violence. This increases the probability of subsequent comorbidity of internalising disorders (depression) and externalising disorders (substance abuse), $S = 1.72$, 95% CI [1.17-2.53] (Putnam et al. 2013). Phenomenologically, women describe experiencing secrecy, menace and humiliation as children, and knowing their mother was unable to protect them from CSA due to domestic violence (Sigurdardottir and Halldorsdottir 2012).

Differences in Experience of Mental Health Problems: Compared to men, women who experience childhood trauma have an increased risk of adult mental health problems. In community studies, women and not men, with a history of abuse had significantly higher lifetime rates of MDD. This equated to 11.7% in women and 5.0% in men. For other diagnoses, women are more likely to experience anxiety disorders (39.4%) compared to men (21.6%) (MacMillan et al. 2001). Women were also more likely to meet criteria for a current diagnosis of PTSD (Gibb et al. 2007). In comparison, the diagnosis associated with a higher percentage in men is CSA and lifetime alcohol dependence at 38.7%. The rate in women is 15.6% (Molnar et al. 2001).

Within psychiatric populations the distribution of diagnoses differs in women to men who have a history of childhood trauma. The two primary diagnoses for women are personality disorder and bipolar disorder. Men have higher rates of schizophrenic disorder and alcohol-related disorders. Kristensen and Lau (2007) identified 62% of women with a history of CSA had previous psychiatric treatment and 21% had previous psychiatric admission. These figures are nearly double that of men (Alvarez et al. 2011). They are also high when compared to the national average of 5% for psychiatric admission in the general population. Suicide attempts also appear gender-specific in psychiatric populations with a history of childhood trauma. Figures obtained from clinical data by Alvarez et al. (2011) show that 52.1% of women with a history of CSA had at least one suicide attempt with an average of 1.5 attempts, compared to 25.9% of men with an average of 0.3% attempts ($p = 0.002$).

Limitations

A major concern for researchers tackling the subject of childhood trauma is the validity and reliability of recall. Retrospective data collection has a number of drawbacks. This is an issue for community samples but especially clinical samples. Maniglio (2010) believes clinical samples are vulnerable to several biases that threaten their validity. For instance, credibility is a possible challenge. As Saleptsi et al. (2004) suggest, the conscious retrieval capacity for autobiographical events could be compromised. Reliability is another concern. The use of retrospective data in most studies introduces the possibility of recall bias (Green et al. 2010). However, Hardt and Rutter (2004) believe this may actually lead to further underreporting of childhood trauma.

Underreporting was evident in a longitudinal study by Banyard et al. (2001). An interesting factor emerged that raised questions from a previous wave of interviews. In the 1990s Wave 2 interviews revealed that 12% of known victims did not report any child sexual abuse, including the incident that brought them into the study (Williams 1994). Banyard and colleagues explain that this enabled their data set to examine outcomes of some survivors who would not appear as survivors in studies that rely on retrospective reports. It also highlights the ongoing concern of underreporting of CSA (Priebe and Svedin 2008). Research by Flett et al. (2012) identified evidence that only 33% of cases of CSA in their study reported the experience to a health professional.

Variations in terminology and meaning used for childhood traumas make it difficult to review like for like. There are a range of terms that can be compared but others are not similar. For instance, domestic abuse has a number of comparisons. In the USA, maternal battery is favoured or simply, family violence. The terms are different but the meaning is similar. There is a difficulty when the meaning is not similar. This is especially telling with generic 'childhood trauma'. The terms covered include child adversity, child maltreatment, and child victimisation. All cover the same purpose but have different meanings within their generic focus. This could mean actual child abuse only or could mean traumatic events such as being a victim of crime (see Dong et al. 2003). This issue also applies to mental health problems. In the literature there is some stretching of diagnostic terms. For example, depression, affective disorder and mood disorder share clinical parameters, but are not diagnoses.

Methodological issues are apparent across the literature. In particular, there are variations in data collection methods and tools used. For example, data collection is conducted via two distinct routes. One is through a variety of questionnaire-based methods and the other is specific rating scales via structured interview. This creates difficulty in making comparisons, with the scales more robust than the questionnaires. Also, the use of quantitative methodology limits understanding of the subject-matter, with over-reliance on cross-sectional survey design. This design raises concern for vulnerability to common method variance (Lindell and Whitney 2001).

Ways Forward

Having considered the literature in the current review there are a number of areas that can be explored further or indeed, added to the focus of childhood trauma and adult mental health problems. The studies are overwhelmingly quantitative from a positivist paradigm. The majority of authors are conducting research from a medical stance, whether by qualification as a psychiatrist or affiliation to a medical school. This can skew the focus, intention, expectation and interpretation of the research toward a medical emphasis (Read 2005, Read et al. 2008). The overall results are convincing and establish a significant association between a history of childhood trauma and the likelihood of lifetime mental health problems.

Having established convincing evidence of an association it might be helpful to understand the meaning of the association. To achieve this, qualitative methodology could yield rich insights into the person's life story, experiences, aspirations, feelings, opinions and values (May 2011). It would prove useful to understand whether childhood trauma enters other areas of the person's life and impact on their well being. An earlier onset of mental health problems is associated with childhood trauma, but there is some time between events. It would be beneficial to find out what is taking place between such events. There is evidence of a picture of abuse that entails more than one episode, more than one abuse, for duration and frequency that appears hard to overcome.

A qualitative focus would attempt to understand childhood trauma experience, the impact, helping process events, recognition of its influence and attempt to reconcile the importance of a lifetime increased likelihood of adult mental health problems. In so doing, this understanding

can bring about a position never attained by medical services in the field of psychiatry (Read et al. 2008). That is, alignment with the person and their trauma history (Hammersley 2004, Lothian and Read 2002, Read 1998). This very real concern affects a large proportion of people and can leave a permanent trace (Spila et al. 2008). Agid et al. (2000) believe that just as smoking is a recognised risk factor for the occurrence of lung cancer, childhood trauma should now be recognised as an important risk factor for mental disorder.

Conclusion

This systematic literature review was conducted to consider research evidence available for the association between childhood trauma and subsequent adult mental health problems. The strict guidelines for systematically accessing, scrutinising and accepting literature was undertaken. All studies that made final inclusion met quality assessment criteria to further enhance rigour. Several aspects emerged, including the nature of childhood trauma, the nature of mental health problems, relationship between the two and the socio-demographic influence of gender. The methodology employed across the body of research is predominantly quantitative which has produced rigorous research findings, but gives further weight for qualitative research on the subject. Additionally, although an association was identified, there is no explanation for possible connection between the two events. As such, theoretical frameworks will be explored in the next chapter.

Chapter 2

Theories of Influence: A Theoretical Framework to Explain the Connection between Childhood Trauma and Adult Mental Health Problems

The systematic review of the literature presented in Chapter 1 provided clear evidence of a strong link between experiencing trauma as a child and the onset of adult mental health problems. The aim in this chapter is to explore a range of theoretical frameworks from psychology that may help explain the connection. These theories attempt to make sense of how childhood trauma impacts the future life course of the victim. They also attempt to understand life experiences of the abused child in terms of internalised self-perceptions (blame, loathing and so on) and external perceptions of others (family, peers and so on).

Eight of the most relevant psychological theories are considered here: the theory of learned helplessness, hopelessness theory, theory of resilience, social defeat theory, cognitive theory, theory of dissociation, psychodynamic theory and attachment theory. Each theoretical framework is critically assessed in terms of their utility in explaining the link between childhood trauma and poor mental health during adulthood.

Theory of Learned Helplessness

Following a series of experiments on the classical conditioning of both animals and humans, Overmier and Seligman (1967) articulated the theory of learned helplessness. There appear to be three principle ideas underlying this theory. Firstly, when people are forced to cope with painful or unpleasant social environments over which they have no control, their mental state changes. Secondly, impact of the environment on their mental state causes a pattern of learning in which people start to interpret the situation as uncontrollable, and expect that the solution (or way out) is beyond their control (Seligman and Maier 1967). Thirdly, this faulty learning results in a sense of helplessness such that people are either unable or unwilling to avoid the unpleasant situation even if options to escape are available.

Learned helplessness is an important principle within cognitive-behavioural theory and may help explain why people can present as passive when confronting negative situations, even if it is within their power to break free (Maier and Seligman 1976; Jackson and Minor 1988). According to Seligman (1978) and Abramson et al. (1978) an important consequence of negative expectations, and associated negative social situations, is poor mental health; especially low self-esteem and depression.

The principles underlying the theory of learned helplessness have been applied to a number of adverse social conditions such as: domestic violence (Palker-Corell and Marcus 2004), poverty (Rabow et al. 1983), discrimination (Broman et al. 2000) and substance abuse (Heffner et al. 2011). Conversely, the theory may also be relevant to understanding how people cope with and are affected by the painful and unpleasant experience of childhood trauma. For instance, Van der Kolk (1987) considered the theory with regards to childhood trauma. He believed that adults, for whom the childhood experience of trauma becomes ingrained, could develop a debilitating sense of helplessness. For these people, the essence of their coping strategies is challenged. They may lose any belief that they can actively influence their own destinies through what Perry (2001) called a defeat reaction, common to many neglected or abused children.

However, there are a number of limitations associated with the theory. For many years, learned helplessness theory has received little attention other than to be challenged (Black 1977; Peterson 1995). An example is the application of learned helplessness to women who have suffered domestic violence. Palker-Corell and Marcus (2004) found that 'battered women' can feel powerless, but do not support the contention that partner abuse results in learned helplessness. Indeed, Flannery and Harvey (1991) believe the applicability of learned helplessness paradigm to trauma victims is more limited than has been generally assumed. A lack of options, lack of skills, opposition to others, internalisation of blame, adaptive survival, and altruism all provide examples of alternative sources of behaviour found among victims of trauma (Flannery and Harvey 1991).

There are elements of this model that make sense with regards to an individual having a specific attributional style. This style influences perception of events by attributing negative outcomes to them and may lead to depression. However, this is not a comprehensive

explanation of the ongoing pervasive influence of childhood trauma. In the latest edition of *Child Psychopathology* by Mash and Barkley (2014) there is only half a paragraph dedicated to the mention of learned helplessness as a theoretical model. They state that learned helplessness theory was superseded by hopelessness theory. With hopelessness, depression evolves from the interaction between exposure to negative events and the pessimistic inferences about causes, consequences and self-implications of events (Mash and Barkley 2014: 241).

Hopelessness Theory

Hopelessness theory was developed as a reformulation of learned helplessness theory. There are two main concepts identified. One is referred to as a hopelessness theory of depression and the second is based on hopelessness as a predictor of suicidal behaviour. The first, hopelessness theory of depression was considered by Abramson et al. (1989). They believed in an attributional style of thinking associated with the onset and maintenance of depression. For example, an expectation that highly desired outcomes will not occur or that highly aversive outcomes will occur, compounded by a view that nothing will change the situation for the better. The second is based on a sense of hopelessness being the most common psychological state experienced by suicidal persons (Shneidman 1998).

People experiencing hopelessness with their situation are trapped with feeling depressed, lacking a future and no way out. One way out is suicide, whether suicidal behaviour through ideation (Huen et al. 2015), parasuicide (O'Connor et al. 2000) or the possibility of hastened death (Breitbart et al. 2000; Kattimani et al. 2015). To assist with the possibility of predicting suicidality, the cognitive therapist Aaron Beck and colleagues devised an instrument for assessing suicidal intent. The Beck Hopelessness Scale (BHS)(Beck et al. 1974) was created to assess three aspects: Feelings about the future, loss of motivation, and future expectations. As expected, people with suicidal behaviour have high scores for depression and hopelessness on the Beck Hopelessness Scale (Beck et al. 1974).

The model of hopelessness has been mainly applied across clinical populations, in particular, psychiatric populations. Research has considered the relationship of hopelessness with a range of diagnostic presentations. For example, Iacoviello et al. (2013) studied the relationship with

depression. They found that hopelessness was followed by a number of debilitating symptoms such as feelings of self-blame, worry, decreased self-esteem, dependency, and decreased appetite. Lysaker et al. (2008) had similar findings with schizophrenia. Evidence suggested potent feelings of hopelessness connected to negative symptoms and anticipating needs will not be met. However, Scher and Resick (2005) study of post-traumatic stress disorder (PTSD) revealed no relationship with hopelessness, other than a shared variance with depression.

Hopelessness theory has also been applied to the experience of childhood adversity and adult reaction to it (Read et al. 2001). An example is a study conducted by Haatainen et al. (2003) who examined the possible association between adverse childhood experiences (ACEs) and hopelessness and gender. An association was evident and showed a similarity across the results. Reporting three or more ACEs were 2.79 times (men) and 2.19 (women) more likely to feel hopeless compared to those without ACEs. Other research used the BHS to determine an association between hopelessness, childhood trauma and adult reaction. These included adult reaction such as psychological adjustment (Browne and Winkelmann 2007), depressed affect (Anda et al. 2006), dissociation and deliberate self harm (Low et al. 2000).

From a social demographic perspective, no gender difference is apparent. However, ethnicity is an influential risk factor in the experience of hopelessness. The research conducted by Hirsch et al. (2012) considered race and ethnicity differences in hope and hopelessness in association with depressive symptoms and suicidal behaviour. They found that the etiological and outcome correlates of hope and hopelessness differ by ethnicity. For instance, trait hope buffered hopelessness for European Americans and Hispanics, but not African Americans. When examined simultaneously, hope remained a significant moderator only in European Americans, whilst hopelessness only in African Americans. Although an interesting distinction, results may highlight cultural difference rather than race/ethnicity.

There are limitations to the theory of hopelessness. Although there is a broad presence within the literature, hopelessness is specifically linked to depressive disorder and suicidality (Beck et al. 1993; Shneidman 1998; Brodsky et al. 2001). This connection is meaningful but appears dependent on the emergence of the mental illness. Indeed, hopelessness is associated with increased awareness of having a mental illness (Carroll et al. 2004). It does not explain the continuation of childhood trauma impact through to adolescence and adulthood. A further

issue is the narrow focus on clinical populations for estimating hopelessness. This has left some questioning its validity in non-clinical populations (Illiceto and Fino 2015).

The Theory of Resilience

The theory of resilience is based around two concepts (Fletcher and Sarkar 2013). The first regards adversity. Davydov et al. (2010) suggests that mechanisms of resilience may differ in relation to their severity. This ranges from resilience against regular everyday stress (mild adversity) to resilience against occasional extensive stress (strong adversity). The nature of the adversity then determines the level of competency needed. The second concept regards positive adaptation. This has been defined as a behavioural manifestation of social competence (Luthar and Cicchetti 2000). Positive adaptation must be conceptually appropriate to the adversity. For example, the use of protective factors to overcome a maladaptive outcome (Rutter 1987) or ability for quick recovery in the face of adverse conditions (Luthar et al. 2000, Leipold and Greve 2009).

Resilience has been further characterised by a range of models to help identify what is taking place. For instance, Perry (2002) considers the key areas affecting capacity for resilience, Richardson (2002) provides a contextualising of the process of resilience undertaken and Baumeister (1998) illuminates the process of rebuilding. Resilience is conceptually distinct from coping or recovery (Bonanno 2004). Resilience is a positive, protective factor (Fletcher and Sarkar 2013), activated through what Van Vilet (2008) termed, self agency. It can also be developed over time. For example, DuMont et al. (2007) discovered in their research that 11% of non-resilient adolescents were resilient by young adulthood.

Principles of resilience theory have been applied to circumstances of risk and adversity, with a particular focus on the psychosocial resources of adolescents and young people in the literature. Main areas of concern are predominantly related to social disadvantage, such as institutional care, fostering, education, and so on. However, there is a body of research concerned with the adversity of childhood trauma. For instance, DuMont et al. (2007) examined resilience in adolescents with a history of child abuse. They found 48% were resilient and a further third developed resilience in adulthood. A similarity discovered by Paris (1997), with resilience the rule rather than exception. However, this does not take into account those

significantly associated with non-resilience. Research by Wingo et al. (2010) exploring resilience and the experience of childhood trauma found non-resilience was influenced by severity of child abuse or trauma exposure.

Bonanno (2004) suggests there is a capacity to thrive after adverse events through a variety of pathways to resilience. Pathways include hope: a hope that the situation will improve (Perry 2002) and spiritual meaning-making, helping to influence survivor resilience (Glenn 2014). In women subject to intimate partner violence (IPV), Lopez-Fuentes and Calvete (2015) found that resilience is also identified in the ability to initially engage external support, followed by reliance on more internal, personal factors. Whichever pathway is undertaken, resilience has been shown to mitigate long-term risk factors such as suicide risk (Roy et al. 2011) and severity of psychiatric symptoms in adulthood (Wingo et al. 2010a).

There are limitations to the theory of resilience. Although the research has given attention to the topic, it merely provides a conceptualisation of how an individual copes with adverse events. Resilience is beneficial as a theoretical model of triumph over adversity. However, it is the absence of resilience that is required here. It is therefore the exception of non-resilience in individuals that requires explanation.

Social Defeat Theory

Research on social defeat stress has mainly focused on experiments with animals, in particular rats and mice. The model of social defeat theory is most associated with the resident-intruder paradigm (Bjorkqvist 2001). The main principle is based on the experience of defeat and subordination to a dominant victor and the subsequent environment. Social defeat stress ensues as a result. This in turn impacts on mental health (Van Bokhoven et al. 2011) and social functioning across the lifecourse (Kovalenko et al. 2014).

The principle of social defeat stress has been applied to several aspects of human experience. Research has identified areas of influence such as upbringing, trauma, victimisation in the workplace, environmental influence and so on. Bjorkqvist (2001) for instance, explored bullying at school, as an unequal power relationship between an aggressor (bully) and victim. Bjorkqvist (2001) believes there is no doubt a victim of school bullying experiences severe

stress due to social defeat. Victims typically exhibit characteristics such as: submissiveness, loneliness, depression, social withdrawal, anxiety, low self-esteem, and are unpopular among their peers. Social factors imperative to recovery from social defeat include empowerment, connectedness and rebuilding a positive identity (Tew et al. 2012).

Further literature has considered the association of social defeat with mental disorder. The majority of research has focused on studies that include schizophrenia (Selten and Cantor-Graae 2007; Selten et al. 2013), experience of psychosis (Lardinois et al. 2011) and major depressive disorder (Pariante and Lightman 2008; Van Bokhoven et al. 2011). For example, Van Nierop et al. (2014) found that symptoms of social defeat act as a mediator in the association between childhood trauma and the experience of psychosis and personality disorder. The experience of social defeat in psychosis has been articulated by Van Winkel et al. (2008) as the subordinate position of outsider status, or what Van Os et al. (2010) refer to as the inferior position of social exclusion.

There are limitations to the theory of social defeat. One major area of concern is the lack of literature on the topic. The original theoretical model is based on animal experiments and theoretically applied to human experience. This offers a meaningful account of what could be taking place following adverse childhood experience. However, research is scant and this theoretical model does not go beyond theory. In an attempt to widen the perspective of social defeat stress, the original principle of resident-intruder paradigm has been extended to include the onset of consequences. Such experiences include worthlessness, suicidality, loss of confidence and loss of self-esteem (Van Neiroop et al. 2014; Selten and Cantor-Graae 2005). These are just as easily explained by the actual experience of childhood adversity.

Cognitive Theory

The cognitive model focuses on two main aspects; namely, developmental deficit and distorted perception. From a developmental perspective, early life stress is associated with abnormal cognitive function that persists into early adulthood (Anderson et al. 2008; Hedges and Woon 2011). This is associated with functional deficits in memory and learning (Eichenbaum et al. 1992; Squire et al. 2004). For example, childhood trauma impacts on the process of recording conscious autobiographical memory. Instead of storing such memory in

the cortex, there is evidence that traumatic memories become stored in regions of the brain associated with emotion and/or the automatic nervous system, e.g. the limbic system, midbrain or brainstem (Dillon et al. 2014). Consequences include reduced ability to process through thought (thinking) or regulate through language (talking) (Courtois and Ford 2009; Harvey 1990). As such, unresolved distress is associated with physical and emotional dysregulation and cognitive intrusions, triggered by trauma reminders across the lifecourse (Dillon et al. 2014).

The impact on learning is what Snow (2009) refers to as a 'double jeopardy'. Maltreated children experience both cognitive and academic delay that affects overall IQ (Campbell et al. 2013; Carrey et al. 1995; Culp et al. 1991). They struggle with language, speech, attention and executive functioning (Beers and De Bellis 2002; Bremner et al. 1995; De Bellis et al. 2009) across trauma experience that cannot be accounted for by the effects of psychosocial stressors such as poverty (Holt et al. 2007; Nikulina et al. 2011; Shonk and Cicchetti 2001; Trickett et al. 1994). Such children are at increased risk of being referred for special education service (Daignault and Hébert 2008; Veltman and Browne 2001) and dropping out of school or leaving with no qualifications (Boden et al. 2007; Gilbert et al. 2009). This results in cognitive and academic delay remaining into adulthood (Navalta et al. 2006; Perez and Widom 1994; Trickett and McBride-Chang 1995).

Cognitive theory also focuses on the concept of distorted perception through cognitive vulnerability (Beck 2008) and the development of bias (Bentall 2003). For example, Beck et al. (1963) discovered that early trauma fosters negative attitudes and biases about the self in the form of dysfunctional schemas. These are activated by later adverse events and lead to systematic negative bias at the core of depression (Beck 1976; Sethi 1964) in children (Scher et al. 2005), adolescents (Abela and Hankin 2008), and adults (Harkness and Lumley 2008).

The concept of bias is explained in two forms (Blackwood et al. 2001). The first is attentional bias as determined through preferential attending to content-specific events (Bentall and Kaney 1989; Fear et al. 1996). For instance, children exposed to trauma demonstrate an attentional bias toward threat-related stimuli (Moradi et al. 1999). The second is attributional bias whereby positive and negative events are explained through internal or external causation (Fiske and Taylor 1991). For example, people with persecutory delusions excessively attribute

positive events to internal causes (self) and negative events to external causes (circumstances or other people) (Kaney and Bentall 1989; Candido and Romney 1990). Research conducted by Ribchester et al. (2010) found that children exposed to trauma focus on negative appraisals of threat ("I am in danger"), locus of control ("I am not in control") and guilt ("I am to blame"). Such negative schema and bias about self, others and the world are associated with the subsequent development of mental health problems (Bentall 2003; Morrison et al. 2005).

Cognitive theory provides a comprehensive and well-researched understanding of the impact of childhood trauma on cognitive development (memory and learning) and perception (negative schema and bias) which can result in the experience of adult mental health problems. However, there are some limitations with the theory. For example, research has mainly focused on depression and found an association with severe depression only. Other mental health problems have been explored but this appears mainly limited to an association with attributional bias identified with some psychotic symptoms such as persecutory delusions and mania (Bentall 2003).

Theory of Dissociation

The 19th century psychologist Pierre Janet was the first to elaborate on dissociation (Janet 1889). He showed clearly and systematically how dissociation is the most direct psychological defence against overwhelming traumatic experiences (Van der Hart and Horst 1989). Subsequent research and scientific opinion has led to variations of the term dissociation and its meaning. Although an association with childhood trauma remains evident in the literature (e.g. Dalenberg et al. 2012; Draijer and Langeland 1999), there are differing opinions as to what dissociation actually is. For example, it has been seen as an altered state of consciousness, a defence mechanism (Cardena 1994) or form of compartmentalisation (Holmes et al. 2005). It is also described by others as interchangeable with the experience of psychosis (Longden et al. 2012; Rudegeair and Farrelly 2008), warranting recognition through a new diagnosis such as dissociative psychosis (Ross 2005) or traumatic psychosis (Romme and Escher 2006).

There is also a growing consensus that dissociation is developmental and linked to attachment theory (Bowlby 1973) through a process of detachment (Allen 2001). For example, research by

Liotti (1992; 2004; 2006) suggests that whilst child maltreatment is an important factor, it is infant disorganization that lays the groundwork for dissociation, where the child detaches from the unresponsive caregiver (Barach 1991; Dutra et al. 2009; Van Ijzendoorn and Schuengel 1996). However, such unresponsive care is identified by Lyons-Ruth et al. (2006) and Dutra et al. (2009) as child maltreatment, they term 'hidden trauma'. These are described as maternal dysfunction (Draijer and Langeland 1999), maternal neglect (Ogawa et al. 1997), inconsistent parenting (Kluft 1984; Mann and Saunders 1994) and family risk (Malinosky-Rummell and Hoier 1991).

Research has also established an association between childhood trauma, dissociation and adult mental health problems within a clinical population (Low et al. 2000) and within a general population (Mulder et al. 1998). In particular, childhood trauma and dissociation has been positively associated with hallucinations (Anketell et al. 2010; Varese et al. 2012); PTSD (Hagenaars et al. 2010), Bipolar Disorder (Oedegaard et al. 2008), Schizophrenia (Yu et al. 2010), OCD (Watson et al. 2004) and implicated in treatment non-response in agoraphobia (Michelson et al. 1998) and anxiety disorders (Spitzer et al. 2007).

The concept of dissociation provides a credible connection between childhood trauma and adult mental health problems. However, there are limitations to the theory. For instance, it is a semantically contentious term (Spitzer et al. 2006), with little known of its aetiology or development (Putnam 1997). It is seen as trauma related, yet not all researchers have found an association (Dutra and Lyons-Ruth 2005). It can be attachment related, yet based on 'hidden trauma' (Lyons-Ruth et al. 2006). Others believe dissociation is actually based on fantasy that engenders confabulated memories of trauma (Giesbrecht et al. 2010). Such a lack of clarity is problematic.

Psychodynamic Theory

Psychodynamic theory centres on the concept of unconscious coping strategies providing a protective adaptation to defend against the experience of childhood trauma (Greenhalgh 1994). Such defence mechanisms are developed in childhood and adolescence to cope with inward and outward anxiety (Finzi-Dottan and Karu 2006; Rice and Hoffman 2014). They are unconscious intra-psychic processes linked to psychological development, personality and

psychopathology (Hauser and Safyer 1995). Indeed, from an early age, the closing of a child's eyes (denial) is the earliest of the reflexes that expresses a defence mechanism (Cramer 2006). Denial is a primitive defence that filters out information that challenges the prevailing perspective (Siegel 2006).

The development of defence mechanisms has been one of the most durable constructs in psychodynamic theory (Perry and Bond 2012). There is evidence that those with experience of child abuse use more immature defence mechanisms (Romans et al. 1999) as a major pathway into adult adversity, such as psychiatric disorders (Britton 2004; Chu 1991; Jackson 2001; Paris et al. 1996). The three major defences identified are repression, splitting and projection.

Repression

Freud (1914: 297) viewed repression as the cornerstone on which the whole structure of psychoanalysis rests. He described repression as having three components. The first is impact on memory. The second is pathogenic effect on psychological and physiological functioning (preventing accurate perception of reality) (see Freud 1926). Thirdly, the existence of an autonomous 'unconscious entity' which activates the repressive process to preserve anxiety-provoking contents (Freud 1915; Fayek 2005). Maggs (1987) likens the concept of repressing unbearable psychological pain to the unconscious as similar to becoming unconscious with unbearable physical pain.

Although many believe in the concept of repression (see Brown et al. 1999; Eagle 2000; Talvitie and Ihanus 2003), the psychology community is polarized regarding its validity (Loftus and Ketcham 1994; Piper 1999). To some, repression is not only out of favour with psychology (Loftus and Ketcham 1994) but an awkward concept that has kept psychoanalysis apart from the rest of science (Nesse 1990). Indeed, there are calls from a number of investigators to abandon repression altogether (e.g. Bonanno and Keuler 1998; Court and Court 2001; Piper et al. 2000). In further consideration, Bonanno and Keuler (1998) suggest that the Freudian concept of repression might be viewed as dissociation. Bowers and Farvolden (1996) believe the two terms are interchangeable.

The debate centres on clarifying whether people remember or forget trauma (Rofé 2008). For example, Freud (1923) argued that most early memories are forgotten due to the conflicted

nature of the material. He believed it is simply turning something away and keeping it at a distance from the conscious (Freud 1915a: 147). This is reiterated by Williams (1995), who found that, 'forgetting' or having 'no memory' of documented child abuse history was actually a common occurrence (particularly if younger at the time of abuse and if molested by a caregiver).

Others believe that people with trauma memories actually deliberately forget the trauma (Epstein and Bottoms 2002; Porter and Birt 2001); or suppress the memory voluntarily rather than unconsciously repress (Kihlstrom 2002). For example, Goodman et al. (2003) found no evidence for a special memory mechanism such as repression unique to trauma events. They believe that forgetting trauma is more likely a lack of willingness to disclose. In addition, a number of researchers considered that a therapeutic search for such repressed memories can lead to the creation of false memories (See Hyman et al. 1994; Loftus and Ketcham 1994; Persinger 1992, 1994; Wade et al. 2007). However, Sivers et al. (2002) simply believes that forgetting eases pain, whether intentional or unintentional.

Splitting

According to psychodynamic theory, early childhood trauma can cause splitting to be retained as a defence to protect against a hostile or empty intrapsychic world (Jacobson 1964; Stewart 1985). It creates a splitting off of affect and denial that allows trauma to be tolerated (Siegel 2006). For example, emotionally robust children can tolerate ambivalence and accept the merging of good and bad; whereas, children who split fight to maintain an idealized stance by distorting reality (Siegel 2006).

Finzi-Dottan and Karu (2006) found that childhood trauma leads to psychopathological presentations in adults that can be explained through their use of immature defence mechanisms such as splitting. Indeed, splitting is a recognised symptom of both borderline and narcissistic personality disorder. Kernberg (1986) suggests that borderline individuals possess predominant hostile and aggressive internalized objects, rather than a positive self. As a result, splitting has a profound impact on intimate relationships (Siegel 2006), through fluctuations in self-esteem, an inability to experience ambivalence, lack of ego and extreme ranges in affect (Akhtar and Byrne 1983).

Even the psychoanalytic community are divided. For instance, Freud believed splitting was a term for dissociation seen as a consequence of repression, not a different mechanism (Knox 2003). In comparison, Klein (1946) believed splitting to be a different process conceived earlier in development as a more severe defence. It is the experience of external reality in a split way through either gratifying good or persecutory bad; usually bad.

Projection

Projection is closely linked to splitting in which good or bad versions of internal objects and parts of the self are projected onto others and related outside of oneself (Hinshelwood 1989). Fonagy (2001) considers projective identification the main defence against the intolerable experience of hostile caregiving. He suggests it forces the child to internalise aspects of the caregiver that the child cannot integrate. To preserve a coherent self, such unassimilated aspects are only dealt with by projecting onto others (Romans et al. 1999).

Projection could arise from experiencing a reduction of internal control over body or affect, resulting from forced submission to the desires or detachment of another (Romans et al. 1999). For example, children who are raised in a frightening atmosphere of violence, neglect and chaos experience being silenced and thus retreat to a private world. In desperation to thrive, the individual splits off and through a mechanism of projection, becomes its own parent (Waldron 2013). As such, the defence of projection is evident in people with a history of child abuse and associated with psychiatric disorder (Romans et al. 1999).

Similar to the theory of dissociation, psychodynamic theory provides a plausible connection between childhood trauma and adult mental health problems. Although there are some interesting considerations regarding the use of defence mechanisms, there are limitations. For instance, the impact on mental health is insufficient in detail. The theories of repression and splitting are disputed both within and without the psychodynamic community. However, a major barrier is the lack of evidence. This is problematic and leaves the theory vulnerable and unscientific.

Attachment Theory

Bowlby (1973, 1980, 1988) attachment theory and the subsequent research, provides a theoretical understanding of attachment development in childhood. Attachment theory conceptualises 'the propensity of human beings to make strong affectional bonds to particular others' (Bowlby 1977). The importance of such bonding can impact on the child in both a positive or negative way through secure or insecure attachment style. Bowlby (1973) proposed that attachment style is developed in childhood through the infant-parent/caregiver relationship. The child internalises experience of early attachment relations and forms a prototype or style of attachment for all later relationships. These attachment styles observed as individual differences in childhood are similar to those presented in adulthood (Fraley and Shaver 2000).

There are two key principles identified by Bowlby (1973) what he called 'working models of attachment'. The first concerns self-image and the second concerns image of others. They are reflections of expectation and beliefs formed on the basis of stable attachment histories, whether secure or insecure (Fraley and Shaver 2000). Such stable attachment histories are considered by Minnis et al. (2007) to describe the degree to which the child is able to use the caregiver as a secure base and experience assuagement of distress. Whereas securely attached children seek proximity and thus mitigate distress, insecurely attached children deal with distress with little reference to the caregiver limiting efficient assuagement (Ainsworth et al. 1978).

Attachment styles of secure and insecure were expanded by Ainsworth et al. (1978) into a three-group typology including secure, anxious, avoidant. Further research by Bartholomew (1990) and Bartholomew and Horowitz (1991) found that avoidant attachment style was split in experiencing subjective distress. Therefore a four-group attachment typology was devised and referred to most in the literature. They consist of Secure, Anxious-Ambivalent, Dismissive-Avoidant, and Fearful-Avoidant. For a summary of each style please see Appendix 2a.

Over the past two decades, attachment theory and research has been productively extended to the study of adult functioning. This research recognises variations in adult attachment styles as predictors of transitional adjustment (Lopez and Brennan 2000; Lopez and Gormley 2002).

These adjustment processes are identified by Rholes and Simpson (2004) as core propositions (see Appendix 2b). However, attachment styles can respond to periods of change. For example, Caspi and Elder (1988) believe major life transitions involving the adoption of new social roles (such as college, marriage, having children, or retiring) provide an opportunity for evaluating and potentially reorganising attachment representations. Should such transitions not be achieved, the attachment style remains intact.

While the formation of attachment is complex, theorists suggest the experience of maltreatment in childhood can affect relationships with others (Bowlby 1980; Finzi et al. 2001). Such early maltreatment can significantly alter normal childhood development arc, leaving the victim with significant long-term impairments (Stirling et al. 2008). For instance, Baer and Martinez (2006) found that maltreated children are more likely than matched comparisons to be rated as insecure. The influence of insecure attachment style subsequently affects several areas through the lifecourse (Finzi et al. 2000), including social skills, functional/dysfunctional relationships, affect regulation, coping in stressful situations and so on.

As a result of insecure attachment style, a negative internal working model of others may occur. This is then imposed onto new attachment figures. The new figures may include teachers and peers through childhood and adolescence; and friends, partners and colleagues in adulthood (Finzi et al. 2000). Research by DiTommaso et al. (2003) and Finzi et al. (2000) found that children who suffered neglect, inconsistent and low maternal responsiveness were effectively blunted emotionally. They were more withdrawn from social interaction with peers, easily victimised, more dependent, anxious and unpopular, possessing less social competence. As a result, the neglected child is unskilled in the formation of peer relationships and subsequently rejected (Finzi et al. 2000; Holbrook et al. 2005).

Attachment relationships are fundamental to individual functioning in childhood and so their disruption impacts across the lifecourse (Crittenden and Ainsworth 1989). In adulthood, as well as social functioning, disrupted attachment relationships are associated with clinical presentations such as stroke, cancer and heart disease (McWilliams and Bailey 2010); suicide, personality disturbances (Bowlby 1977; Felitti et al. 1998); alcohol and substance abuse (Hazan and Shaver 1987, 1990; Maunder and Hunter 2001). In particular, research has focused attention on association with depression (Bifulco et al. 2002a; Bifulco et al. 2006; Dozier et al.

2008; and Williams and Riskind 2004). Such research supports Bowlby's original proposal that links childhood attachment to dysfunctional emotional functioning many years later (Morley and Moran 2011). As such, it provides a compelling connection between childhood trauma and adult mental health problems.

There are a number of limitations to the theory of attachment. One major concern is reliance on examining the relationship between child and caregiver being based on western nuclear familial situations. As such, anthropologists have suggested attachment theory resembles a 'folk theory', by abstracting elements of experience from one culture to formulate a universal view (Quinn and Mageo 2013). Cultural difference is not accounted for. For instance, across the world there are cultures that encourage detachment during childhood. One example is German parents placing strong demands for self-reliance on their infants by discouraging closeness to the mother (LeVine and Norman 2001). This cultural difference enables the child to tolerate separation and play alone as necessary. In the United Kingdom or United States such infants are dismissive-avoidant. On the other hand, a high proportion of Japanese infants present as insecure-resistant due to infrequent separation from their mothers (Quinn and Mageo 2013).

Several other concerns cited in the literature include, 1, Attachment does not encompass the whole parent-child relationship (Arredondo and Edwards 2000; Byrne et al. 2005). 2, Feminist theory is concerned with how lives of women are viewed negatively as mothers (Birns 1999). 3, Limited importance placed on the experience of multiple caregivers (Hazan and Shaver 1994). 4, A lack of clearly defined limitations to the theory (Bolen 2000). 5, Variation of psychological stance. For instance, there are differences in outlook and research focus between attachment theorists from developmental psychology (childhood) and social psychology (adulthood). Another example is terminology used in the literature. Fearful -avoidant insecure attachment is described as 'disorganised' in childhood and 'unresolved' in adulthood. Howe (2011) believes that in order to present a concise, coherent picture of attachment, one has to ride roughshod over such debates.

Conclusion

This chapter has explored eight theoretical frameworks that may offer an understanding of what is the developmental connection between childhood trauma and adult mental health problems. Not all children who experience trauma will go on to have development problems in their life and subsequent mental disorder. However, for many this is an inevitable destination. To better explain the experience, a theoretical model from psychology is required to offer a framework with which to identify with. Each theory has been considered for their relevant contribution to this concern. All provide an explanation, but it is attachment theory that appears the most meaningful and dominant framework.

Bowlby (1973) attachment theory has sufficient theoretical, research and practical consideration to illuminate the relationship between childhood trauma and the impact on developmental bonding, throughout the lifecourse. Insecure attachment has a negative influence on the social world of individuals, supported by the contribution of other psychosocial deficits. This may contribute to the development and subsequent longevity of mental disorder. As such, a literature review considering association between childhood trauma, attachment style and poor mental health will form the next chapter.

Chapter 3

The Association between Childhood Trauma, Attachment Style and Poor Mental Health

This systematic literature review builds on the findings of chapters 1 and 2. In chapter 1 an association was established between childhood trauma and mental health problems. Chapter 2 considered a range of theoretical frameworks from psychology that provide understanding of what may be taking place between the experience of childhood trauma and the onset of adult mental health problems. Attachment theory emerged as the most comprehensive explanatory framework. The aim of this chapter is to draw together this plethora of research in order to gain a more detailed understanding of the explanatory role attachment plays in accounting for the association between childhood trauma and poor adult mental health.

The literature review will be organised around three questions: 1) Is there an association? This considers strength of association between childhood trauma, attachment style and adult mental health problems. 2) What is the nature of the association? This section considers specificity of childhood trauma, specificity of attachment style and specificity of mental health problem in the association. 3) What are the consequences of the association? This gives consideration to impact on development, social attachments and vulnerability to increased risk of further trauma.

Methods

Search Strategy

A systematic search of the literature was undertaken in January 2015 and updated in July 2015 to examine what association researchers have derived between childhood trauma and attachment style and mental health problems. A thorough computer search of the most relevant health and social sciences data bases was undertaken, as suggested by Younger (2004). These included Academic Search Complete, AMED, CINAHL, Medline, PsycArticles, and PsycInfo. A hard copy search was also undertaken to consider the reference list of each study identified.

Table 3.1: Search Terms for Childhood Trauma, Attachment Style and Mental Health Problems.

Concepts:	Variation/Synonym:	Location:
Child Abuse	Childhood Abuse Childhood Neglect Childhood Victimization Childhood Trauma Childhood Adversity Childhood Maltreatment	Abstract Title No Field Selected
Connection	Cause Experience Relationship	No Field Selected
Attachment Style	Attachment Disorder Attachment Theory Attachment Pattern Insecure Attachment	Abstract Title No Field Selected
Mental Health Problems	Adult Mental Health Mental Health Issues Mental Illness Mental Disorder Mental Disease Psychosis	Title Abstract No Field Selected

It can be seen in Table 3.1 that the search commenced using key word search of three classifiers of ‘child abuse’ and ‘connection’ and ‘attachment style’ and ‘mental health problems’, as described by Ely and Scott (2007). The Boolean operator ‘and’ was the only additional word used to combine all three classifiers throughout the search to yield articles that include all identified keywords (Cronin et al. 2008). The exercise was then repeated with the classifiers altered to incorporate different synonyms in use across the literature.

Variations commenced with childhood abuse, childhood neglect, and childhood trauma and so on. Connection was replaced by the synonyms ‘cause’, ‘experience’ and ‘relationship’. Attachment style was replaced by attachment disorder, attachment theory, attachment pattern, and insecure attachment, added systematically to elicit further studies. Variations on mental health problems included adult mental health, mental health issues, and mental illness and so on. The location of the key word within the database search commenced using the field, ‘Title’ and ‘Abstract’, but with little success. Choosing ‘No Field Selected’ proved more successful in yielding results.

Table 3.2: Inclusion and Exclusion Criteria for Childhood Trauma, Attachment Style and Mental Health Problems

Criteria:	Inclusion:	Exclusion:
Date	2000-2015	≤2000
Language	English Only	Non-English
Gender	Male and Female	None
Age	Childhood trauma before age 18 years	Trauma after age 18 years
Geography	UK, USA, Canada, NZ, Australia, Europe, Israel	Africa, Asia (China, India etc)
Study Focus	Relationship between Childhood Trauma and Attachment Style. Relationship between Attachment Style and Mental Health Problems. Relationship between Childhood Trauma, Attachment Style and Mental Health Problems.	Clinical Provision Service provision Clinical Treatment/Intervention Learning Disability Neurology only Adoption
Childhood Trauma	Intra-familial abuse Sexual Abuse Physical Abuse Emotional Abuse Neglect Divorce of Parents Witness of Domestic Abuse Traumatic Illness Traumatic Significant Death (Parent)	Extra-familial abuse Institutional Abuse Church Abuse Autobiographical Memory War Victim Sexual Offending Adoption
Attachment Style	Attachment Theory Attachment Pattern Attachment Disorder Insecure Attachment Secure Attachment	Parental Attachment Religion Relationship with God Attachment to Pets
Mental Health Problems	ICD-10: Anxiety Disorders Depressive Disorders Psychosis Schizophrenic Disorders Personality Disorders Psychiatric Symptomatology	Substance Abuse Focus Dementia
Text Format	Full Text Full Access Primary research	Abstract Only Non-primary research Commentaries

Inclusion and Exclusion Criteria

Table 3.2 lists the inclusion and exclusion criteria used for the literature search.

The timeframe was set at 2000 – 2015 to enable an up-to-date view of the literature. Although the theory of attachment has been a feature of research for over thirty years, it is necessary to

elicit its current position and relevance within the literature. In addition, the focus of childhood trauma has altered in recent years as a result of high profile cases of child abuse and ongoing media attention. Indeed, the landscape of mental health and in particular, psychiatry has changed from institutional care to a more community focused care. Consideration of the most recent research should therefore be within the timeframe of such changes.

Age is restricted to studies that include participants reporting childhood trauma experienced before age 18 years old, the age of adulthood in law in the United Kingdom (UK) (NSPCC 2015). The age of 16 years old is too low as it excludes children aged 17 and 18 who may still be subject to trauma at home. Cultural values and social norms are required to be similar in order to promote a more homogeneous body of research to explore (May 2011). To achieve this, the range of countries for inclusion consisted of developed nations from North America, Europe and wider Australasia. Studies from Africa, Asia and South America were excluded on the basis of cultural and social difference. Differences include the distinction between single and multiple mothering, nuclear versus extended family, industrialised versus non-industrialised communities. These present stark cultural contrasts in beliefs, practices and institutions, and in particular, surrounding attachment (Quinn and Mageo 2013).

The study focus is based on research that considers a relationship between childhood trauma and attachment style and mental health problems. Research that focuses on clinical, treatment or service provision is excluded. Their focus does not meet the requirements for this review. Studies based on learning disability, neurology only or institutional care, have a different remit to this review and are excluded. Instead, similar to chapter 1, intra-familial abuse is the principal inclusion criteria that refers to family and close caregiver relationships such as incestuous abuse. It is abuse experienced within the immediate vicinity of kinship and ordinary life experience. Childhood trauma identified for inclusion is child sexual abuse (CSA), child physical abuse (CPA), child emotional abuse (CEA), neglect and domestic abuse; and wider child traumas including traumatic childhood illness and death of a parent.

On the other hand, extra-familial abuse is indiscriminate by nature and excluded due to its extremely broad definition. Extra-familial abuse includes war victims, institutional abuse, church or faith related child abuse and adoptive studies. All are external events and as such,

excluded. Instead, intra-familial abuse focuses on the nature of family ties, stronger bonds and level of trust between abusers and abused, relative to other forms of extra-familial abuse.

To consider attachment theory, the term attachment style is used initially as it covers the lifespan experience. To ensure a wide range of research is identified, variations of attachment terms are included such as, attachment theory, attachment pattern, attachment disorder, insecure attachment and secure attachment. The focus is specific to the individual experiencing the attachment style, which is conceptually based on their view of self and others. Therefore parental attachment and attachment to pets is excluded. There is also a body of research that focuses on attachment with regards to religion and attachment relationship with God. This will not be considered here for the same reason as above.

Again, similar to chapter 1, mental health problems established within DSM-V (APA 2013) and ICD-10 (2015) diagnostic criteria are considered for inclusion. Such recognised diagnoses as anxiety disorders, schizophrenic disorders and depressive disorders are suitable. Also, the presence of psychiatric symptomatology as determined by valid research measures is included. Studies focused specifically on substance abuse are avoided due to their limitation to a particular behaviour. Therefore, a focus on addiction to drugs and abuse of alcohol are behaviours not considered here.

Search Process and Outputs

The process of study selection was recorded on a 'Preferred Reporting Item for Systematic Reviews and Meta-Analyses' (PRISMA) flow diagram (Moher et al. 2009). See Figure 3.1 below for the flow diagram.

A total of 3392 articles were identified. From these 677 were duplicates and removed, resulting in 2722 articles for consideration within the inclusion and exclusion criteria. Of these, 2578 were excluded as not relevant. The full text for 144 articles was reviewed in detail. As a result a further 108 were deemed non-primary research such as commentaries and abstract only and excluded. This left 36 studies which satisfied the reviews inclusion criteria. Additional records of 39 articles were obtained from hard copy and grey literature searches, but 33 did not meet the review criteria and therefore ineligible for inclusion. This systematic review of the literature yielded 42 relevant studies that focus on the relationship between childhood

trauma and attachment style, attachment style and mental health problems or the three areas combined.

Quality Assessment

To assess the quality of the 42 studies identified from the systematic review process, a quality assessment checklist (QAC) was developed from Caldwell et al. (2005) framework for critiquing health research. The framework was considered suitable for the current review because it can be applied to quantitative and qualitative research methodologies. Quantitative and qualitative studies were assessed separately. For each paper, each criterion was rated as fully met (Yes = 2), partially met (Partially = 1), not sufficiently met (No = 0) or not possible to assess (cannot tell = 0). Total scores (out of 36) and percentage scores were calculated for each paper. From this quality assessment process, 0 studies were excluded as they all reached the accepted cut off point of 75% or above. To examine the reliability of the quality assessment ten articles were rated by a researcher independent to the present review. Inter-rater reliability was calculated using the Kappa statistic. The results of the inter-rater analysis were Kappa = 0.7140 (substantial agreement) (see Appendix 1a).

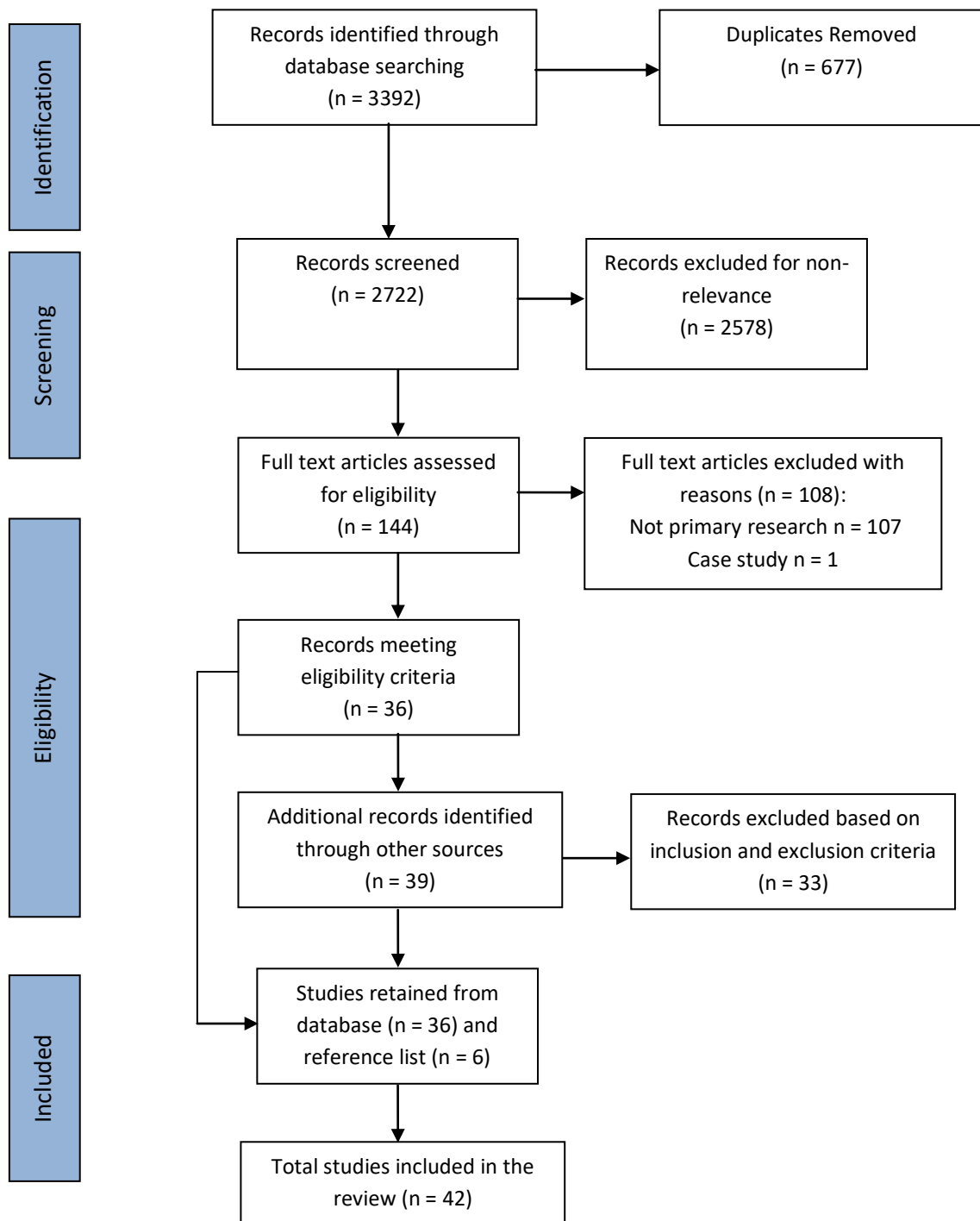


Figure 3.1: PRISMA 2009 Flow Diagram: Childhood Trauma, Attachment Style & Mental Health Problems

Source: Moher et al. (2009).

Characteristics of the Literature

In total there are 42 studies, as identified in Table 3.3. The key geographical location for the research is North America, with (24/42), USA (14) and Canada (10). Other studies are located within Europe (14/42) and Israel (3). The principle methodology is quantitative, with 39 of 42 studies. Samples are drawn from three main populations of clinical, community and student. Clinical samples retrieved information from adults either referred or who consecutively accessed psychiatric treatment or trauma counselling. The majority of community samples were recruited from advertising in local centres. All studies assessed attachment security. Some focused on an association with childhood trauma, some with mental health outcomes but most considered both. Twelve studies were gender-specific, with eleven assessing women only and one, men only. The combined number of participants for this review is N = 11,667.

Study Quality

None of the studies fulfilled all of the Caldwell et al. (2005) quality criteria. However, the quality of studies is excellent, with an average of 80% attained by most. Across the body of literature there are variations of method, sampling, data collection measures, emphasis and findings. This restricts the ability to make direct comparisons. The method most used is cross-sectional survey design by 30 studies. Whilst this limits the opportunity to consider causal links, eleven used a comparison group to improve rigour. In addition, there are four longitudinal and two prospective studies with unmatched comparisons. Only two studies assessed participants with unequivocal recording of child abuse through child protection services.

The sample size recruited for quantitative research ranged from 28 participants from a community population (with a matched control group of 16) through to 876 from a student population. Only three studies used randomised selection and two restricted this to the comparison group. Most studies used convenience sampling through advertising, consecutive clinical attendance and referral processes. Most studies were generic in their assessment of childhood trauma and mental health outcomes, but some considered a specific focus such as child physical abuse or psychosis.

Data collection processes were similar, but most of the measures differed. For example, over thirty questionnaires were used, which is common across trauma literature (Pereda et al. 2009). Although similar in focus, there is an array of different questions and terminology that makes direct comparison difficult. The most prominent questionnaire identified for attachment style is the Adult Attachment Interview (George et al. 1996). This was used in eight studies. The Child Trauma Questionnaire by Bernstein and Fink (1998) was used by four studies to assess trauma history. Assessment of mental health outcome depended on the study focus. For instance, one study used the Positive and Negative Syndrome Scale (PANSS) (Kay et al. 1987) for psychosis. Another used the Beck Depression Inventory (BDI) (Beck et al. 1961) for their focus on depression.

Table 3.3: Literature Review: Childhood Trauma, Attachment and Mental Health Problems

No	Authors, Date, Location	Study Aim	Study Design	Sample Information	Methods of Data Collection	Information re: Reliability/Validity	Key Findings	Quality Rating
1	Alexander 2009 USA	Current Intimate Partner Violence severity, childhood abuse histories, affect dysregulation, family-of origin experiences, and AAI attachment classification.	Cross-sectional Survey	93 battered women seeking services at eight different agencies for IPV in the Mid-Atlantic area.	Structured interview	Validated measures used: -Conflict Tactic Scale 2 -Adult Attachment Interview -Dissociative Experiences Scale - Taxon -Personality Assessment Inventory Inter-rater reliability tested.	Multiply victimized women were significantly more likely to have CSA history, witnessed violence, and parent-child role reversal. Women who were unresolved in their attachment were more likely to be multiply victimized in adulthood.	90%
2	Baer and Daly Martinez 2006 USA	Meta-analysis to examine effect size of maltreatment and insecure attachment. Conduct a subpopulation analysis to investigate effect size by type of maltreatment.	Meta-Analysis	A computerized search for studies between 1988 and 2005 = 8 studies with n =791 Also non-maltreated comparison group n=775	Data were abstracted independently by both authors and cross-referenced from the bibliographies.	Strict inclusion/exclusion criteria Comprehensive Meta-Analysis software used.	Overall the findings support the maltreatment/insecure attachment hypothesis. The subpopulation analysis, although extremely small, indicates that different types of maltreatment affect the magnitude of effect.	90%
3	Berry, Barrowclough & Wearden. 2009 UK	Tested specific predictions regarding associations between adult attachment, perceived earlier experiences of care giving and trauma in a sample of people with psychosis.	Cross-sectional Survey	N = 80 patients from community and inpatient recruited. Inclusion criteria = ICD-10 diagnosis of schizophrenia, schizotypal or delusional disorder.	Structured Interview	Validated measures used: -Psychosis Attachment Measure -Parental Bonding Instrument -Trauma History Questionnaire -Positive and Negative Syndrome Scale -Calgary Depression Scale for Schizophrenia Also re-test and inter-rater reliability.	Partial support for associations between previous interpersonal experiences and adult attachment and justify the inclusion of measures of attachment in future studies testing cognitive models of psychosis.	80%
4	Berry, Wearden and Barrowclough. 2007 UK	Examined attachment networks & associations between general attachment style and attachment in relationships with parents and psychiatric staff in patients with psychosis.	Cross-sectional Survey	N = 58 MH outpatients from Greater Manchester recruited from a larger sample of patients.	Structured Interview	Validated measures used: -Psychosis Attachment Measure The informant measure had good levels of inter-rater reliability.	Both attachment anxiety and avoidance measured with reference to close relationships in general and attachment in key worker and parental relationships	75%
5	Bifulco, Kwon, Jacobs, Moran, Bunn & Beer. 2006 UK	Investigate the relationship between attachment style and disorder using the ASI. Examining outcomes for both anxiety disorders and depressive disorders.	Prospective Design	154 community women aged 26 to 59 years, originally studied in 1990-1995. Adult vulnerability = 57 Child vulnerability = 55 Comparison group = 42	Postal questionnaire Structured Interview	Validated measures used: -Child experience of care and abuse -Attachment style interview -Structured clinical interview Also benchmarked examples and team consensus.	Insecure attachment predictive of anxiety & MDD. Attachment significantly associated with childhood neglect/abuse. Fearful & Angry-dismissive attachment partially mediates the relationship between childhood adversity & disorder.	85%

6	Bifulco, Moran, Ball and Lillie. 2002 UK	Considers whether type and degree of insecure attachment adds to vulnerability in predicting depression and specificity of style to type of vulnerability.	Prospective design	N = 302 community-based women. 222 high-risk and 80 non-matched comparison group	Semi-structured Interview	Validated measures used: -Self evaluation and social support interview -Attachment style interview -Child experience of care and abuse -Present state examination Checked by raters blind to psychiatric and attachment status	The presence of any marked to moderate level of insecure attachment significantly related to poor support, low self-esteem, childhood neglect/abuse and provided the best model for clinical depression.	80%
7	Busuito, Huth-Bocks & Puro 2014 USA	Explore the role of romantic attachment in understanding the relationship between child abuse and PTSD in adulthood.	Longitudinal study	N = 120 Mothers in third trimester.	Structured Interview	Validated measures used: -Childhood Trauma Q -Posttraumatic stress disorder checklist-civilian -Experiences in close relationships Q-R Conflict Tactics Scale-2	Higher levels of attachment anxiety and attachment avoidance related to more PTSD symptoms.	85%
8	Carpenter and Chung 2011 UK	Investigate the interrelationship between childhood trauma, attachment, alexithymia and severity of OCD.	Cross-sectional Survey	N = 82 with OCD recruited from online self-help group and non-matched comparison group without OCD N = 92	Structured Interview	Validated measures used: -Yale-Brown Obsessive Compulsive Scale -Childhood Trauma Q-SF -Experience in close relationship inventory -Toronto Alexithymia Scale	Correlation between childhood trauma and attachment avoidance and positively associated with alexithymia.	90%
9	Cloitre, Stovall-McClough, Zorbas, and Charuvastra 2008 USA	Evaluated potential roles of emotion regulation and social support expectations in linking adult attachment classification and psychiatric impairment.	Cross-sectional Survey	109 Women participants 16-65 yrs self-referred for posttraumatic stress disorder (PTSD) related to CSA and/or CPA.	Structured Interview	Validated measures used: -Child maltreatment interview -Adult attachment interview -Social adjustment scale Four independent coders, blind to all study information coded the transcribed interviews. Excellent interrater reliability	Results suggest the relevance of attachment theory in understanding the myriad psychiatric outcomes associated with childhood maltreatment & in particular, focal roles emotion regulation and interpersonal expectations may play.	80%
10	Desrosiers, Sipsma, Callands, Hansen, Divney, Magriples & Kershaw. 2014 USA	Investigate the relationship between romantic attachment style and depressive symptoms between both members of pregnant adolescent and young adult couples.	Cross-sectional Survey	N = 592 total participants. 296 Pregnant females & their male partners.	Structured Interview	Validated measures used: -Experience in close relationships inventory -Centre for epidemiological studies-depression scale	Avoidant and anxious attachment are significantly positively related to depressive symptoms.	80%
11	Dimitrova, Pierrehumbert, Glatz, Torrisi, Heinrichs, Halfon and Chouchena 2010 Swiss	To better understand the mechanisms involved in the process of trauma it may be essential to confirm whether attachment can mediate the link between CSA and future adult mental functioning.	Cross-sectional Survey	28 adult female subjects older than 18 yrs, reporting at least one episode of CSA in their childhood and 16 demographically matched control group.	Structured interview x 3	Validated measures used: -Early trauma inventory -Global assessment of functioning -Adult attachment scale	Relationship between CSA, attachment and psychological outcome in adulthood, found that capacity to maintain closeness in relationships in CSA survivors mediates the link between CSA and subsequent psychological outcome	80%

12	Finzi, Har-Even, Shnit and Weizman. 2002 Israel	Examine levels of depression, anxiety, aggression, suicidality, impairments in the maturation of defense mechanisms, and avoidant attachment style due to parental CPA.	Cross-sectional Survey	N = 114 children divided into three groups: 41 CPA, 38 neglected, 35 non-abused comparison group	Structured Interview	Validated measures used: -Attachment style classification Q -Children's depression inventory -Trait anxiety inventory -Child suicide potential scales	CPA showed an avoidant attachment style, specific depressive and suicidal symptomatology, high anxiety, high aggression and primitive defense mechanisms.	75%
13	Frederick and Goddard 2008 Australia	This study sought to obtain greater knowledge and understanding of the life circumstances of a group of people who had experienced adversity and abuse in childhood.	Phenomenological	The sample size was 20 interviewees aged between 19 and 51. They had varied family backgrounds, from lower socioeconomic to more advantaged situations.	In-depth Interviews over two to three hours.	Data was reviewed on three separate occasions.	Interviewees detailed multiple risks to their development during childhood and adolescence, including experiences of child abuse. As suggested by attachment theory, this study supports the notion of developmental continuities from adverse childhood experiences into later life.	75%
14	Godbout, Dutton, Lussier and Sabourin 2009 Canada	The effects of violent experiences in childhood on current domestic violence and marital adjustment, using adult attachment theory as a conceptual framework.	Cross-sectional Survey	Participants consisted of 315 men and 329 women in long-term romantic relationships.	Postal survey.	Validated measures used: -Experience in close relationships Q -Conflict Tactics Scale 2 -Dyadic Adjustment Scale Cronbach's alpha used to assess reliability of own questions on early exposure to violence. Its value reached 0.78.	The association of exposure to parental violence and subsequent adult attachment. In addition to being related to their own attachment behaviors, women's exposure to parental violence was positively related to having a male partner anxiously attached.	85%
15	Gumley, Taylor, Schwannauer, MacBeth. 2014 UK	Identify, summarise and critically evaluate studies that investigated attachment amongst individuals with psychosis.	Systematic Literature Review.	21 studies comprising 1453 participants. 68.4% male.	Data extracted via computerised databases.	Strict quality criteria.	Small to moderate association between greater attachment insecurity, poorer engagement with services, more interpersonal problems, more avoidant coping strategies, more negative appraisals of parenting and more severe trauma.	80%
16	Hankin 2006 USA	To understand proximal mechanisms to which a distal history of childhood maltreatment & adversity are associated with prospective elevations of depressive symptoms in young adulthood.	Multiple Methods	N = 652 young undergraduate students for study one and an independent sample of students in study two N = 75.	Structured Interview	Validated measures used: -Life experiences Q -Cognitive Style Q -Adult attachment Q -Beck Depression Inventory -Mood and anxiety symptom Q	A childhood history of emotional maltreatment and insecure attachment predicted depressive symptoms. No specific childhood maltreatment predicted anxiety symptoms.	85%

17	Ivarsson, Granqvist , Gillberg and Broberg. 2010 Norway	Relationship between state of mind (SoM) with regard to attachment, (unresolved/disorganized), loss and abuse, & OCD in adolescence. Also MDD association with insecure attachment and OCD.	Cross-sectional Survey	N = 100 Adolescents, 25 with OCD, 25 with MDD, 25 OCD with MDD and 25 randomly selected control group.	Structured Interview	Validated measures used: -Diagnostic interview for children and adolescents -Kiddie schedule for affective disorders and schizophrenia -Adult attachment interview All transcripts were analysed by a second blinded coder. All coders were reliable.	60% of participants with OCD classified as dismissing (Ds), 40% of the DD group as unresolved with regard to loss or abuse (U) and 28% as cannot classify, while 44 and 36%, respectively, of those with OCD/DD group classified either Ds or U.	80%
18	Joubert, Webster and Kisst Hackett 2012 Canada	Investigated the associations between unresolved/disorganized attachment, cognitive functioning, and dissociative symptomatology.	Cross-sectional Survey	60 adolescents with a history of maltreatment referred to a mental health clinic.	Structured Interview	Validated measures used: -Adult attachment projective picture system -Adult psychopathology scale -Woodcock-Johnson tests of cognitive ability-III Scales used show median reliability estimates above 0.90.	Strong evidence that youth exposed to abuse and maltreatment by caregivers are at greater risk to show disorganized, poorly integrated internal models of attachment relationships, as well as trauma-related symptomatology.	85%
19	Kisiel, Fehrenbach, Liang, Stolbach, McClelland et al.. 2014 USA	Examine the role of CSA in combination with other caregiver-related trauma.	Cross-sectional Survey	Recorded data from a clinical sample of 3 groups: Trauma and CSA N = 501, Trauma and no CSA N = 1108, Non-carer trauma and no CSA N = 142. Total N = 1,823	National Child Traumatic Stress Network Core Data Set	Validated measures used: -PTSD Reaction Index -Trauma symptom checklist for children-alternate -Child behavior checklist -Trauma history profile Measures show strong psychometric properties	Youth with caregiver trauma had earlier onset and longer duration of trauma. CSA had increased clinical profile. Caregiver trauma and attachment problems. CSA = PTSD, MDD, suicidality and sexualized behaviour.	75%
20	Levendosky, Huth-Bocks and Semel 2002 USA	Examined the impact of domestic violence, child abuse and attachment style on adolescent mental health and relationship functioning.	Cross-sectional Survey	N = 111 adolescents and their mothers via advertising and flyers to at-risk communities, centres and at-risk teen programs.	Structured Interview for both adolescent and mother	Validated measures used: -Severity of violence against women scales -Childhood trauma Q -Adult attachment scale -Beck depression inventory -Post-traumatic stress scale for family violence -Parenting style survey -Perceived social support scale -Network of relationships Inv -Conflict in adolescent dating relationships inventory. -Children's depression inventory -Trauma symptom checklist.	Both attachment and family violence experiences negatively impact on mental health outcomes.	75%
21	Mason, Platts and Tyson. 2005 UK	How schemas relate to attachment style in mental health service users. Investigate relationship between psychological distress, psychological difficulties, & attachment.	Cross-sectional Survey	Participants were 72 clients (32 men (45%) and 40 women (55%)). Mean age 39, currently receiving care from 3 urban mental health out-patient services.	Structured Interview	Validated measures used: -Clinical outcomes in routine evaluation -Experiences in close relationships -Young schema Q. CORE Good internal consistency. High internal consistency and factorial validity.	81% of the participants had insecure attachment style. Fearful group were most distressed across several domains of the CORE. Individuals symptoms & difficulties & schemas meaningfully related to their adult attachment style.	75%

22	Muller, Gragtmans, and Baker 2008 Canada	Investigate attachment as a potential mediator in the relationship between history of abuse and social support.	Cross-sectional Survey	876 university students Participant pool was made up of 82.4% women and 17.6% men. The majority between the ages of 16 and 24 years.	Self-completion	Validated measures used: -Relationship scales Q. -Relationship Questionnaire -Multi-dimensional support scale - Record of maltreatment experiences self-report Reliability considered for each measure.	Relationships among abuse, attachment and social support can be explained through a mediational model. Specifically, both dimensions of attachment, view of self and view of other, mediated the effects of childhood physical abuse on perceived social support.	85%
23	Muller, Sicoli and Lemieux. 2000 Canada	Examines relationship between adult attachment style and PTSD symptomatology in a volunteer sample of adults who reported experience of childhood abuse.	Cross-sectional Survey	66 participants completed. They included 24 men and 42 women with a mean age of 33 years.	Structured Interview	Validated measures used: - Record of maltreatment experiences self-report -Relationship scales Q -PTSD symptom checklist Test re-test reliability identified.	In total, 76% of participants endorsed one of the three insecure attachment styles (dismissing, fearful, or preoccupied), demonstrating significantly greater insecure than secure attachment in this group.	75%
24	Muller, Thornback & Bedi 2012 Canada	Investigated adult attachment in close relationships as mediator in relationship between 3 types of parent perpetrated childhood abuse (i.e., CEA, CPA and DV) and symptomatology.	Cross-sectional Design	876 university students Participant pool was made up of 82.4% women and 17.6% men. The majority between the ages of 16 and 24 years.	Self-completion	Validated measures used: -Relationship questionnaire -Relationship scales Q -Young adult self-report -Trauma symptom checklist-40 -Record of maltreatment experiences self-report Test Retest coefficient and Internal consistency scores described.	When all three types of parental maltreatment (psychological, physical, and exposure to family violence) were considered simultaneously, attachment mediated the relationship between only psychological abuse and symptomatology.	75%
25	Myhr, Sookman and Pinard. 2004 Canada	Examines concurrent associations of attachment security, psychopathology and recollections of early parental interactions, in adults with OCD, MDD and in healthy controls.	Cross-sectional Survey	36 patients with OCD (17 females, 19 males), 16 patients with unipolar depression or dysthymia (12 females and four males) and 26 healthy controls (18 females and 8 males).	Structured Interview	Validated measures used: -Revised Adult attachment scale -Parental bonding instrument -Tale-Brown Obsessive-compulsive Scale -Symptom checklist-90 R -Beck depression inventory	OCD & MDD groups were more insecure than controls. MDD recalled less caring mothers than OCD group, while the OCD group was same as controls on PBI measures. Married status associated with greater security.	85%
26	Neufield Bailey, Moran and Pederson 2007 Canada	Investigated associations between maltreatment history, Unresolved attachment, and symptoms of complex trauma.	Longitudinal Study	62 women who gave birth in adolescence (less than 20 yrs old).	Structured Interview	Validated measures used. -Adult attachment interview -Childhood trauma interview -Childhood trauma Q -Trauma symptom inventory -Borderline features scale of Personality Assessment Inventory	The associations between maltreatment, complex trauma symptoms, and Unresolved attachment suggest early traumatic events can have enduring impact on integrative functioning. Associations may be apparent in at-risk populations.	80%

27	Pielage, Gerslma and Schaap. 2000 Netherlands	Examined whether attachment style is a mediator between stressful events and psychological symptoms or alternatively, whether the experience of stress mediates between attachment style and psychological symptoms.	Concurrent design	51 student couples, together for at least 3 months, were recruited on campus at the University of Groningen. Mean age was 22.76 years.	Structured Interview and video recording	Validated measures used: -Relationship questionnaire -Survey of recent life experiences -Symptom Checklist-90 R Cronbach's Alpha considered for each tool.	Stressful events mediated the association between fearful attachment and psychopathology. Fearfully attached individuals are more prone to perceive events as stressful, which in turn increases their vulnerability to experience psychological symptoms.	75%
28	Pielage, Luteijn and Arrindell. 2005 Netherlands	Examined role of intimacy in the current romantic relationship as a possible mediator of relationship between adult attachment and psychological distress in a clinical and community sample.	Concurrent design	N = 92 individuals in the process of psychotherapy recruited at several outpatient clinics in Netherlands. Community comparison group N = 121	Structured Interview	Validated measures used: -Relationship questionnaire -Adult attachment scale -Waring intimacy questionnaire. -Loneliness scale -Center for epidemiological studies depression scale -Satisfaction with life scale Cronbach alpha reliability or coefficient was applied to all measures.	Attachment insecurity was negatively, related to intimacy in the current romantic relationship. Insecure attachment was positively related to loneliness and depression.	75%
29	Ponizovsky, Nechamkin and Rosca. 2007 Israel	Examine whether schizophrenic patients and nonclinical comparison differ in attachment styles and if attachment styles are associated with symptom patterns and the course of schizophrenia.	Cross-sectional Survey	N = 30 patients with schizophrenia, stabilized on antipsychotic medication, recruited from various hospitals. N = 30 Non-clinical matched comparison group	Structured Interview	Validated measures used: -Relationship questionnaire -PANSS Internal reliability was satisfactory. Cronbach's Alpha and test retest was high for Hazan and Shaver Questionnaire.	Patients with schizophrenia scored significantly higher on insecure attachment measures (avoidant and anxious/ambivalent) than controls. Association of insecure attachment styles with severe course of the illness.	85%
30	Ponizovsky, Vitenberg, Baumgarten-Katz and Grinshpoon. 2013 Israel	Compare outpatients with schizophrenia having distinct self-reported attachment styles by the severity of specific symptoms of psychosis and experienced emotional distress.	Cross-sectional Survey	N = 100 patients who consecutively attended a community outpatient clinic.	Structured Interview	Validated measures used: -PANSS -Relationship questionnaire -General health questionnaire Validity and reliability considered for each measure.	Preoccupied & fearful-avoidant attachment patterns were associated with higher scores of psychotic and affective symptoms. Dismissing-avoidant style was associated with only anxiety.	80%
31	Raque-Bogdan, Ericson, Jackson, Martin and Bryan. 2011 USA	Examine the relationships among attachment, self-compassion, mattering, mental health, and physical health.	Cross-sectional Survey	N = 208 undergraduate students (153 women, 44 men, 11 not reported).	Structured Interview	Validated measures used: -Experiences in close relationships-Revised -Self-compassion scale -mattering scale -Medical outcomes SF v2 Health survey Validity and Test/re-test reliability considered for all measures.	Both attachment anxiety and avoidance were significantly and negatively related to mental health. Self-compassion and mattering both mediated the relationship between self-reported levels of attachment avoidance and anxiety and mental health.	75%

32	Reinert and Edwards 2009 USA	Examined gender difference in sequelae associated with levels of CPA and CEA. Using attachment and psychological outcome.	Cross-sectional Survey	N = 272 non-clinical sample of university students.	Structured Interview	Validated measures used: -Revised attachment to God scale (substitute mother and father for God) -Trauma symptom checklist-40 -Substance abuse subtle screening inventory -Self-report index Reliability considered for all.	Strength of mother-daughter attachment moderated adverse psychological symptoms of father abuse. Mother-son did not.	75%
33	Scott Brown and Wright. 2003 UK	Investigate (a) attachment classifications between a clinical and non-clinical group, and (b) links between classifications and self-reported relationship difficulties and symptomatology.	Cross-sectional Survey	N = 30 adolescents (10 males, 20 females) aged 14 to 20 yrs. 15 Clinical group and 15 Non-clinical group.	Structured Interview	Validated measures used: -Adolescent separation anxiety interview = response to photographs -Inventory of interpersonal problems -Youth self-report form Coded by two researchers with satisfactory interrater reliability.	Clinical group: significantly more ambivalent and avoidant attachment patterns compared to the non-clinical group. Ambivalent attachments reported social difficulties, anxiety/depression, internalizing symptoms and thought disorder.	90%
34	Smith, Gamble, Cort, Ward, Conwell and Talbot. 2012 USA	Examined the interaction of attachment orientation and acute social maladjustment as risk factors for death ideation.	Cross-sectional Survey	N = 106 women with MDD and a childhood history of CSA. Uncontrolled pilot of interpersonal therapy (IPT) N = 36 and randomized clinical trial for IPT and treatment as usual N = 70	Structured Interview	Validated measures used: -Experiences in close relationships -Social adjustment scale -Hamilton rating scale for depression Reliability and internal consistency considered for all	Social maladjustment and DD was associated with greater endorsement of death ideation. Avoidant and anxious attachment moderated social maladjustment and death ideation in some domains.	75%
35	Stalker, Gebotys and Harper 2005 Canada	Evaluated predictive capacity of a measure of insecure adult attachment over predictive capacity of demographics, abuse history, psychiatric severity, trauma exposure, & current social support.	Longitudinal Study	134 women with histories of child abuse consecutively admitted to the Program for Traumatic Stress Recovery (PTSR), in a specialized psychiatric hospital.	Structured Interview	Validated measures used: -Symptom checklist-90 -Modified PTSD symptom-scale-report -Traumatic stress institute belief scale-revision L -Rosenberg self-esteem scale Good reliability and validity for each measure	Women with histories of severe child abuse and multiple types of lifetime trauma, higher levels of insecure attachment and current perceived social support have more effect on outcome. High levels of insecure attachment reduce a woman's response to intervention.	75%
36	Stanton and Campbell 2014 Canada	Examined the attachment-health link and moderating role of perceived social support.	Cross-sectional Survey	116 married couples.	Two hour laboratory session and separate completion of a book of questionnaires	Validated measures used: -Experiences of close relationships-Revised -Serious of illness rating scale -MOS short-form general health survey -Social provisions scale -Dyadic adjustment scale -Big five inventory Reliability considered for most.	Anxiously attached individuals reported greater depression, more medical symptoms, bodily pain, poor overall health & social functioning.	85%

37	Stovall-McClough and Cloitre. 2006 USA	Examine unresolved trauma by the Adult Attachment Interview and current psychiatric symptoms, focusing on PTSD and dissociation, in adult female childhood abuse survivors.	Cross-sectional Survey	60 women referred for PTSD, ranging in age from 19 to 62 years M = 36.10.	Structured interview	Validated measures used: -Adult attachment interview -Clinician administered posttraumatic scale for DSM IV -Structured clinical interview for DSM IV axis 1 disorders -Trauma symptom inventory Interrater reliability and internal consistency adequate to good	Four-way classifications reveals over half sample (57%) classified as unresolved regarding either abuse, loss, or both as compared with secure (22%), dismissing (13%), or preoccupied (8%) classifications. Child abuse = 91% CSA, 70% CPA, & 62% both.	75%
38	Surcinelli, Rossi, Montebanarocci and Baldaro. 2010 Italy	Examine differences in anxiety and depression related to differences in attachment models of the self and of others and whether personality traits mediate this relationship.	Cross-sectional Survey	274 healthy volunteers (141 female participants; M age = 32.8 years, age range = 18–55 years) from a community sample	Self-completed instruments.	Validated measures used: -Relationship questionnaire -Big five questionnaire -Beck depression inventory -State-trait anxiety inventory Internal consistency was good for each measure	Secure attachment in adults was associated with better mental health, while insecure attachment styles characterized by negative thinking about the self were associated with higher depression and anxiety scores.	75%
39	Unger and De Luca 2014 Canada	Identify the insecure adult attachment style associated with CPA.	Cross-sectional Survey	552 female and 294 male university students.	Self-completion	Validated measures used: -Experiences of close relationships -Multidimensional scale of perceived social support -Comprehensive child maltreatment scale Internal consistency was good	A history of CPA is associated with attachment avoidance and some support for attachment anxiety.	75%
40	Wallis and Steele 2001 UK	To confirm hypothesis of elevated levels of attachment insecurity among adolescents in psychiatric residential units, stemming from the absence of a consistent secure base in childhood.	Cross-sectional Survey	39 adolescents (29 females and 10 males) recruited from five regional psychiatric adolescent units in England. Age-range of participants was between 13 & 20 years	Semi-structured Interview	Validated measures used: -Adult attachment interview Interviews classified by an expert rater. High reliability and blind to clinical notes of sample.	The overall findings confirm that psychopathology is associated with profound insecurities in terms of one's state of mind regarding attachment experiences. Secure N = 4, Dismissing N = 20, Preoccupied N = 11, Cannot classify N = 4.	75%
41	Ward, Lee, and Polan. 2006 USA	Is unresolved loss or trauma relating to early attachment experiences, as assessed by the AAI, associated in predictable ways with types of psychopathology?	Cross-sectional Survey	60 Women recruited from a larger study. N = 30 with diagnosis of psychopathology. N = 30 no diagnosis comparison group	Semi-structured and Structured Interview	Validated measures used: --Structured clinical interview for DSM III-R -Adult attachment interview -Life events inventory -Social support interview	Women diagnosed with psychopathology are significantly more likely to be classified non-autonomous (insecure) AAI classifications than are women without a diagnosis.	85%
42	Weinfield, Whaley and Egeland 2004 USA	This longitudinal study examines continuity and discontinuity of attachment quality from infancy to late adolescence	Longitudinal Study	125 late adolescents (71 males, 54 females). Subsample of a larger longitudinal study.	Structured Interviews	Validated measures used: -Ainsworth strange situation -Adult attachment interview -Data from original correlate measures used.	Disorganized infants were significantly more likely than organized infants to be insecure or unresolved in late adolescence. Additionally, infant disorganization predicted unresolved abuse scores on the AAI for those participants who experienced childhood abuse.	75%

Key Findings

The key findings will address three main areas. The first is to identify if an association exists between childhood trauma, attachment and mental health outcome. The second is to determine the nature of that association; and the third is to provide information related to the consequence of such an association.

Is There an Association?

Across all 42 studies there is a consensus of findings identifying an association between childhood trauma, insecure attachment style and poor mental health outcomes. This is evident regardless of the research focus on specific aspects of the association or specificity of trauma, attachment or outcome. The relationship varies in strength but is present at a significant level.

Association between Childhood Trauma and Attachment

The 25 studies focused on childhood trauma and attachment style show a significant and positive correlation. For example, Godbout et al. (2009) cross-sectional survey of over 300 couples identified $P < 0.05$, level of significance, similar to Unger and De Luca (2014). Muller et al. (2008) survey of over 800 students found modest to moderate correlations ($r = -.12$, $P < 0.01$). In addition, Baer and Daly Martinez (2006) meta-analysis of 8 studies with statistically significant effect size identified an 80% greater odds ratio of having an insecure attachment style if maltreated in childhood. This compares with 36% in non-maltreated comparison groups.

Although the majority of studies use cross-sectional design, results are substantiated by prospective and longitudinal studies. For example, Bifulco et al. (2006) prospective study with comparison group found insecure attachment style was significantly associated with childhood trauma ($r = 0.30$, $P < 0.0001$). They also identified a dose-response effect between childhood trauma and degree of insecurity. This was similar to Weinfield et al. (2004) longitudinal study of 267 primiparous women, discovering that participants with insecure attachment throughout childhood and adolescence were significantly more likely to have experienced child maltreatment, $t(39.6) = 2.45$, $P < 0.019$.

One cross-sectional survey by Berry et al. (2009) using Pearson correlations found only partial support for predicted associations. They assessed a clinical population of individuals with schizophrenic type disorders, focusing on specificity of perceived earlier experience, attachment and outcome. Post hoc tests revealed that participants with a history of childhood trauma differed significantly from those with trauma in adulthood at the .05 level ($P = .023$) (Berry et al. 2009).

Association between Attachment and Mental Health Outcome

Studies focused on attachment style and mental health outcome numbered 35 in total. All found a statistical significance for a relationship between the two. For example, Wallis and Steele (2001) discovered 90% of their adolescent clinical sample ($N = 39$) recruited from across five regional units had insecure attachment. Of interest is that 59% of the sample was judged unresolved regarding past loss or abuse with an attachment figure. Other studies identified a range of association between 63% up to 100% for certain attachment styles and mental health problems (Ward et al. 2006; Mason et al. 2005; Ponizovsky et al. 2007; Scott Brown and Wright 2003; Pielage et al. 2000). Although mainly cross-sectional design the results are similar in prospective studies. For example, Bifulco et al. (2006) logistic regression analyses established that insecure attachment significantly relates to poor mental health outcome in follow-up ($OR = 6.67, P < 0.001$).

Association between Childhood Trauma, Attachment and Mental Health Outcome

There are 18 studies combining assessment of childhood trauma, attachment style and mental health outcome. Some are generic and some are specific but each found a significant association. An illustration of this is identified in clinical samples in particular. For example, Carpenter and Chung (2011) research focused on obsessive-compulsive disorder (OCD). They found that childhood trauma was significantly positively associated with attachment insecurity ($B = 0.351, SE = 0.094, P < 0.001$). This in turn was significantly positively associated with alexithymia ($B = 0.551, SE = 0.087, P < 0.0001$), which was significantly positively associated with the severity of OCD symptoms ($B = 0.0338, SE = 0.0116, P < 0.01$). Regression analysis established the specificity of attachment style. In addition, Stovall-McClough and Cloitre (2006) identified women who had experienced child abuse and unresolved attachment had a 7.5-fold increase in poor mental health outcomes. Similar findings are established in Busuito et al.

(2014); Bifulco et al. (2006); Levendovsky et al. (2002), and so on, across community, clinical and student populations.

Further studies of interest include Hankin (2005) prospective study that suggest an insecure attachment style, negative cognitive style and negative events help account for the link between childhood trauma and adult depression. Dimitrova et al. (2010) examined the relationship between child sexual abuse (CSA), attachment and psychological outcome. CSA severity predicted insecurity of attachment. However, through regression analysis with psychological outcome (dependent variable) and abuse and attachment (predictors), abuse did not predict adult outcome ($\beta = -0.15$, $t = -0.75$, $P < 0.46$), but attachment predicted psychological outcome ($\beta = 0.55$, $t = 3.37$, $P < 0.002$). This is significant and supports Carpenter and Chung (2011) and Levendovsky et al. (2002) who believe the significant relationship between childhood trauma and mental health problems is not direct, but interacts dynamically with attachment and other personal factors.

A number of studies considered the influence of secure attachment. For example, having no history of childhood trauma increases the likelihood of a secure attachment. Figures show that over 73% of those with no history of trauma attain a secure status (Finzi et al. 2002, Scott Brown and Wright 2003). This compares to only 16% of those with a history of childhood maltreatment (Ponizovsky et al. 2007, Stovall-McClough and Cloitre 2006). Secure attachment is associated with lower levels of life stress, increased levels of support and emotional stability (Ward et al. 2006; Surcinelli et al. 2010); and increased likelihood of positive mental health outcomes (Scott Brown and Wright 2003, Pielage et al. 2005).

The evidence suggests that childhood trauma influences attachment security and insecure attachment influences mental health outcomes. This seems apparent with regards to generic consideration or specificity of focus presented in the studies reviewed here. Alternatively, where there is no history of childhood trauma and a secure attachment present, it appears to mitigate against the increased likelihood of poor mental health outcomes. Any low rates of association identified here can be explained in terms of difficulties with defining the variables involved.

What is the Nature of the Association?

In the previous section the literature shows there is a significant association between childhood trauma, attachment style and mental health problems. This section will explore the nature of the actual relationship. In view of complexity identified, information is divided into the specific areas of interest that emerged. These include Age of Onset, Specificity of Trauma, Specificity of Attachment Style, Specificity of Diagnosis, Severity of Symptoms, and Trauma across the Lifecourse and, Gender and Race.

Age of onset

Age of onset for certain childhood trauma appears to hold significance with regards to the possible trajectory of ongoing insidious experience. This then informs the type of damaging insecure attachment experienced, such as disorganised/unresolved. For instance, Kisiel et al. (2014) studied a clinic-referred large national sample of 1823 youth to assess exposure to a wide range of traumas in three distinct groups of caregiver-related (CR)-CSA, CR Trauma and non-CR Trauma. They found that CR-CSA was unique in their patterns of trauma exposure and characteristics as measured by age of onset and time span of exposures. The experience of CR - CSA increased attachment problems and clinical profile, with presentations of post-traumatic stress disorder (PTSD), major depressive disorder (MDD) and suicidality. Indeed, all CR traumas in childhood had an earlier age of onset, a longer duration and were more chronic (Kisiel et al. 2014). They create a greater range of functional difficulties and increase severity of clinical symptoms, compared with multiply traumatised youth without CR trauma histories.

Earlier age of childhood trauma increases insecure attachment and people who have insecure attachment styles are more likely to have an earlier onset of mental health problems. This has been highlighted in two studies. The first is Bifulco et al. (2002b) community study of 222 women at risk of depression with 80 comparison women. They discovered that the onset of teenage depression was significantly related to insecure attachment style, in as many as 68% of the sample. Such findings were also discovered by Ponizovsky et al. (2007) in a clinical sample of 30 people with schizophrenic disorders and 30 healthy controls. Using two-tailed t-test comparisons they revealed that compared to those securely attached those with insecure attachment (avoidant and anxious) were significantly younger at onset of their illness $t(1) =$

11.2 and 4.67, respectively; both $ps < 0.001$). Also experiencing longer psychiatric hospital stay, $t(1) = 2.29$, $p < 0.05$.

Specificity of Trauma

Some studies focused specifically on the nature of the trauma experienced. This was usually child abuse or the experience of domestic violence (DV). For example, Godbout et al. (2009) community study assessed over 600 randomly selected couples to consider the effects of violence in childhood. Child physical abuse (CPA) was experienced by 24% of women and 30% of men, with 47% of the sample also witness to domestic violence. Such childhood experiences significantly correlated with insecure attachment in adulthood. For instance, zero-order correlations were CPA, (0.10, $P < 0.05$), child emotional abuse (CEA), (0.12, $P < 0.05$) but DV was only significant if psychological, (0.14, $P < 0.05$). Witness to physical DV only became significant with adult intimate-partner violence (IPV) (Godbout et al. 2009).

Levendosky et al. (2002) community study of 11 adolescents and their mothers discovered that higher levels of DV and exposure to any child abuse (CPA, CSA, CEA and neglect) were related to insecure attachment. Hierarchical multiple regression analyses revealed that child abuse was significantly related to greater avoidant attachment style specifically ($\beta = .31$, $p < .01$). Muller et al. (2012) had similar findings within their cross-sectional survey of 876 students. Their regression analyses identified that CEA, CPA and exposure to DV all predicted insecurity of attachment. For example, CEA was ($\beta = .39$, $p < 0.001$). Insecure attachment significantly predicted psychopathology, up to ($\beta = .87$, $p < 0.001$).

Specificity of Attachment Style

Within the literature, there are two main typologies of attachment style considered. One is Ainsworth et al. (1978) three-attachment typology of secure, anxious and ambivalent used by 22 studies. The second is the four-attachment typology of Bartholomew and Horowitz (1991) with secure, anxious, dismissive-avoidant and fearful-avoidant used by 8 studies. Eight of the remaining studies used insecure attachment as a generic term and 2 only focused on unresolved attachment. There are variations in some terms used in certain data collection measures. For example, closeness meaning avoidant and autonomous meaning secure. Others such as Bifulco et al. (2006) have added their own addition of enmeshed attachment. Although often interchangeable, it makes comparison difficult.

Anxious attachment style was considered by Berry et al. (2009) and Busuito et al. (2014). They discovered an association with a range of anxiety disorders, including trauma symptoms or specifically PTSD (Berry et al. 2009, Busuito et al. 2014) and psychosis (Berry et al. 2009). An important determinant of anxiety in attachment is the experience of childhood trauma involving significant others and in particular, the severity of the trauma (Busuito et al. 2014). Likewise, Levendosky et al. (2002) found that the experience of child abuse is linked to anxious attachment and subsequent trauma symptoms in adulthood. From an attachment point of view, anxious attachment is correlated with the experience of being over-controlled in earlier care-giving relationships (Berry et al. 2009). Avoidant attachment is opposite, experiencing a lack of care in earlier care-giving relationships.

In separating avoidant attachment style into fearful-avoidant and dismissing-avoidant, Bifulco et al. (2006) attempted to discover the nature of disorders that share a connection. In so doing, they revealed that fearful and dismissive attachment styles were significantly related with a variety of more specific disorders as a result of childhood neglect or abuse. For instance, fearful-avoidant is closely related to disorders such as social phobia, anxiety disorders and major depressive disorder; and dismissive-avoidant attachment is closely related to anxiety disorders only. This separation is further explored by Stovall-McClough and Cloitre (2006) who found that unresolved (fearful-avoidant) attachment was a result of either abuse, loss or both.

Specificity of Diagnosis

Throughout the literature there are a range of specific diagnostic presentations considered in relation to childhood trauma and insecure attachment style. These are mainly identified in clinical populations with established diagnoses, but also revealed in community and student samples. These include three broad diagnostic disorders of depressive, anxiety and psychotic. Other studies refer to mental disorder in generic terms, such as psychopathology.

Depressive Disorder (DD) was the main specific focus or discovery in the studies explored here. One community study that focused specifically on depression as an outcome was conducted by Bifulco et al. (2002b). In their sample of 302 women, they found that 15% reported a clinically significant depression before the age of 20. Teenage depression was significantly related to insecure attachment compared to those with no teenage depression ($p < 0.005$). Ivarsson et al. (2010) clinical sample of 75 adolescents and 25 controls, found that those with unresolved

attachment style are five times more likely to experience DD. One reason may be the influence of their negative internal working model, synonymous with higher rates of negative self evaluation. In addition, Myhr et al. (2004) found similar results with significantly higher levels of attachment insecurity in a clinical sample of adults with depression, compared to healthy controls ($F=6.34$, $df = 2.72$, $P < 0.003$).

Anxiety disorders include PTSD and OCD. Only Bifulco et al. (2006) prospective study focused specifically on anxiety as an outcome within a community sample of women and comparison. Through Pearson correlations, they found that overall anxiety correlates with insecure attachment, but mainly dismissive attachment ($r = 0.17$, $p < 0.004$). For PTSD, attachment avoidance and attachment anxiety are positively correlated with PTSD symptoms (Busuito et al. 2014; Muller et al. 2000). Both insecure attachment styles have an internal working model that represents a negative self-view, compared with dismissive and secure that identifies positive self-view. PTSD is therefore correlated with a negative view of self and a positive view of other. However, this is not a feature of anxiety disorders per se. People with OCD are predominantly associated with dismissive attachment (Ivarsson et al. 2010; Carpenter and Chung 2011). Although their internal working model is of a positive self-view, it incorporates a negative view of other.

A longitudinal study by Neufield Bailey et al. (2007) found an association between childhood trauma experience and complex trauma symptoms with dissociation. Insecure attachment style was identified in 72% of participants, with 37% classified unresolved. The majority (71%) with unresolved (fearful-avoidant) attachment reported CSA. Indeed, CSA even predicted unresolved status with regard to loss and/or trauma. The study then identified a range of associated symptoms that include unresolved complex trauma and dissociation. Although specific to CSA, the significance remains important for the relationship with unresolved attachment and the emergence of dissociative symptomatology.

Within the literature a relationship was found between insecure attachment style and psychotic disorders. For example, Ponizovsky et al. (2007) researched people with schizophrenia specifically and identified that 56.7% had an avoidant attachment style and 26.7% had an anxious attachment style. This appears linked to severity of symptoms of the psychosis. For instance, those with a higher severity of negative symptoms (functioning) had

significantly higher scores on avoidant attachment style. Whereas, those with a higher severity of positive symptoms (psychosis) scored significantly higher on insecure attachment style per se. Results established by Berry et al. (2007) similarly discovered that people with psychosis had higher avoidant attachment style. However, the same people reported lower levels of avoidant attachment in parental relationships. This may suggest that reliance on parents remains intact, even when external social relationships are impaired.

Severity of symptoms

People with insecure attachment style in adulthood and who experience psychosis have increased severity of symptoms. This includes the addition of substance abuse and symptoms of anxiety. In research by Ponizovsky et al. (2013) insecure attachment style was associated with more severe positive symptoms of psychosis. Symptoms included higher delusion and persecutory ideation, emotional distress and also high levels of reported anxiety and depression. In addition, higher attachment anxiety was associated with greater severity of voices (auditory hallucination) and greater distress in relation to the voices (Gumley et al. 2014). Conversely, security of attachment is linked to less positive symptoms of delusions, hallucinations and paranoia.

Trauma across the Lifecourse

Early childhood trauma is shown to impact across the lifecourse. This includes the ongoing experience of insecure attachment style into adulthood (Weinfield et al 2004), and the ongoing occurrence of mental health problems into adulthood (Hankin 2006). As Neufeld Bailey et al. (2007) state, such early traumatic events have an enduring impact on integrative functioning in adulthood. Its pervasive nature can be further experienced through ongoing occurrence of abuse in adulthood (Berry et al. 2009). An example is Busuito et al. (2014) research that discovered greater total child abuse severity was correlated positively with insecure attachment, PTSD symptoms and current abuse in adulthood, such as IPV severity.

Gender and Race

There are two distinct areas of socio-demographic significance. One is gender, with a number of studies focusing on the specific experience of women. Some studies compared results with men, but no study explored men only. As in chapter one, the findings for women-only focused research are worthy of highlighting. Their specific relationship with childhood trauma

(particularly CSA), insecure attachment and mental health outcomes presents significant insights. The second is based on race, but this is only one study and racial comparison was the central feature of the research.

Gender: Women only studies: The focus for the studies involving women-only varied with regards to actual trauma experience, attachment style and psychiatric diagnosis. With a focus on a clinical sample of 109 women with histories of severe childhood abuse, Cloitre et al. (2008) found that 63% reported CSA, 50% CPA, 62% witnessed domestic violence and 45% reported neglect. Large proportions of the sample also reported additional traumas, with 36% exposed to two, 35% exposed to three, and as many as 29% exposed to three or more additional traumas. Average number of traumas reported was lower for secure than those with insecure attachment.

Reinert and Edwards (2009) found a strong relationship between child abuse severity and attachment avoidance specifically. High attachment avoidance in women was then positively associated with the experience of PTSD symptoms. Indeed, Stovall-McClough and Cloitre (2006) purport that their results indicate that women with unresolved (fearful-avoidant) regarding abuse were 7.5 times more likely to be diagnosed with PTSD compared with those without unresolved attachment. These results suggest there are important aspects of an ongoing traumatised mental state resulting from early abuse. In Stalker et al. (2005) research, they believe the inclusion of lifetime trauma, high levels of insecure attachment and a lack of perceived social support have more impact on mental health outcomes in women. This was compared to a range of variables such as type of child abuse reported, marital status, education, income, or number of types of lifetime traumatic events.

A study by Ward et al. (2006) discovered the inclusion of personality disorder, not mentioned in any of the other studies. They randomly selected 30 subjects with a diagnosis of psychopathology and a comparison of 30 subjects without a diagnosis from a previous study sample. Their findings identified women with dismissing-avoidant attachment were more likely to receive a diagnosis of personality disorder (63% versus the other three attachment groups at 33%). In addition, women with unresolved-avoidant attachment were equally likely to receive a diagnosis of personality disorder, as depressive disorder or a co-morbid diagnosis

(35%). Such findings identify important insights, given the low prevalence of personality disorder diagnosis in the female population (Coid et al. 2006).

Racial groups: A US community study that assessed 296 pregnant couples by Desrosiers et al. (2014) considered the relationship between attachment style and depression within racially specific groups. The groups included Non-Hispanic Black, Non-Hispanic White and Hispanic. Both avoidant and anxious attachment styles were evident across the sample, with a positive relationship identified with depression. However, this appeared more gender-specific, with males scoring significantly higher on avoidant attachment and females significantly higher on anxious attachment and depressive symptomatology. An association was identified across all racial groups between anxious attachment and depressive symptoms; whereas, avoidant attachment was related to higher depressive symptoms for all racial groups except Hispanics. One explanation is cultural difference, with Hispanic culture emphasising interdependence and collectivism, thereby mitigating the impact.

What are the Consequences?

The previous section has detailed the actual nature of the association between childhood trauma, attachment style and mental health outcomes. This section will now consider the evidence identified in the literature for the consequences that befall individuals with experience of such an association. With the majority of studies focusing attention on the relationship, a number of the consequences identified here may only be supported by one research study.

Several consequences are discussed in the literature that appears to fall into three categories. The first category details the impact on personal development of aspects such as internal working model, social development and working memory. The second category identifies the impact on social relationships, through capacity for closeness, lack of help-seeking and subsequent lack of social support. Finally, the third category considers the impact of vulnerability to increased risk through adult victimisation, prolonged psychiatric treatment and suicidality.

Impact on Personal Development

Internal Working Model

Few studies specifically identified the influence of internal working models of attachment (Bowlby 1973). For example, Muller et al. (2008) examined a sample of 876 students to determine the mediating role of attachment on the relationship between CPA and perceived social support. Using several models of analyses they found exposure to CPA predicted lower positive view of self and others at a statistically significant level. CPA also predicted lower perceived social support and poor attachment relationships across the lifecourse.

Another research study involving a university sample was conducted by Pielage et al. (2000), who assessed 51 student couples. They found no empirical evidence for attachment style having such a mediating role as in Muller et al. (2008) study. Instead, stressful events mediated the association between fearful-avoidant attachment style and psychopathology. Individuals with negative view of both self and others through a fearful attachment are more prone to perceive events as stressful, which increases vulnerability to psychopathology (Pielage et al. 2000). In comparison, secure attachment is associated with a positive internal working model of self and others and subsequent improved outcomes (Surcinelli et al. 2010; Bifulco et al. 2002). Although students do not represent the general population, Barrett (2005) suggests they do provide a diverse population and one that may be ideal for the study of attachment due to threatened esteem.

Impaired Working Memory

Joubert et al. (2012) was the only study to consider cognitive functioning. They assessed a clinical sample of 60 adolescents with unequivocal records of childhood trauma. The research identified fearful attachment status as being meaningfully linked to cognitive efficiency in the form of impaired working memory ($\beta = -.48, p < 0.001$). Also, a mediation model linking fearful attachment as predictor, cognitive efficiency as mediator, and trauma symptomatology as an outcome variable was supported by the data (Joubert et al. 2012). It is recognised that impaired working memory is associated with mental disorders (Rose and Ebmeier 2006; Silver et al. 2003), but identifying a relationship with attachment style brings new insights. However, results should be considered with caution; given the mean age of the sample is 14.4 years. No

account is offered for possible adjustment and development in the predictor, the mediator and the outcome variable with age.

Impaired Social Development

Chronic and early traumas by caregivers are classic examples of complex trauma exposure that has a pervasive influence on social and emotional development and attachment relationships (Kisiel et al. 2014). For example, Smith et al. (2012) found through a logistic regression model, women with a history of CSA have significant social maladjustment ($\chi^2_{(6)} = 19.524, p < 0.007$, Nagelkerke $R^2 = .274$) and experience maladjusted intimate relationships ($\chi^2_{(6)} = 13.783, p < 0.05$ Nagelkerke $R^2 = .415$). Muller et al. (2008) found that adults with a history of CPA also experience social impairment, but mediated through attachment dimensions (view of self and other), $p < .001$. Indeed, each mediator independently predicted higher levels of the outcome variables (perceived social support). Furthermore, Mason et al. (2005) identified an association between attachment styles and impaired social functioning. Their study of 72 participants from a clinical population found that fearful attachment was characterized by greater social isolation, $M = 4.29, SD = (1.55)$ and social relationships, $M = 2.17, SD = (0.85)$; both $ps < 0.01$. This compares to secure attachment, $M = 2.19, SD = (1.15)$ and $M = 1.05, SD = (0.69)$ respectively.

Impact on Social Relationships

Capacity for Closeness

An inability for closeness is a consequence associated with child abuse, attachment and mental disorder. For example, Dimitrova et al. (2010) studied two samples of adult women, one with a history of CSA and a control group. Women with CSA history had a reduced capacity for closeness and intimacy in relationships ($r = -0.46, p < 0.01$). Using a mediation model, Sobel test and confirming through regression analysis they confirmed that CSA did not predict adult outcome ($\beta = -0.15, t = -0.75, p < 0.46$), whereas close attachment predicted subsequent psychological outcome ($\beta = 0.55, t = 3.37, p < 0.002$). Therefore, capacity to maintain closeness with attachment figures mediates the consequences of CSA on subsequent psychological outcome. This is supported by Reinert and Edwards (2009) who found that maintaining the mother-daughter attachment moderated several adverse psychological symptoms in response to maltreatment. In addition, Berry et al. (2007) conducted a study within a clinical population

to determine the median number of significant emotional attachments. The study sample identified only two people of significance, compared to a population average of 10 people (Doherty and Feeney 2004).

Lack of help seeking

Several obstacles to help seeking are presented in the literature. An inhibition to seek support from a caregiver or significant others can manifest as a result of the child abuse and insecure attachment. This may be established through the child developing an internal working model that represents the self as worthless, the world as threatening (Hankin 2006). Indeed, it also includes a low expectation of support (Muller et al. 2008) and the possibility of an abusive lifecourse that limits attempts to seek help (Frederick and Goddard 2008). Carpenter and Chung (2011) discovered that avoidant attachment strategies result in attempts to deal with distress alone for people with OCD and alexithymia. Their marked dysfunction in social attachment and emotional awareness not only impacts the ability to seek support but also a failure to know when.

Lack of social support

One major area of concern throughout the literature is a lack of social and familial support. As a result of traumatic experiences in childhood, Frederick and Goddard (2008) suggest the majority leave home at the earliest opportunity. They report having little or no contact with their family of origin and report an increased likelihood of involvement in violent adult relationships. As such, there is a lack of perceived and actual social support (Muller et al. 2008). Bifulco et al. (2002) believe this is fuelled through insecure attachment being significantly related to negative self-evaluation, 71% versus 36% with secure attachment ($p < 0.001$). Also, lacking support from partner or close confidant (72% insecure versus 13% secure, $p < 0.0001$).

All insecure attachment styles have significant difficulties with social support, but the experience varies. For instance, people with anxious attachment style report lower perceived social support from others, poorer social functioning and more mental distress (Pielage et al. 2005; Stanton and Campbell 2014). On the other hand, those with ambivalent attachment patterns report increased difficulty socially, but this lies in their inability to socialise or be

sociable (Scott Brown and Wright 2003). In comparison, those with secure attachment predict more supportive relationships and higher levels of perceived support from a range of sources.

Vulnerability to Increased Risk

Adult Victimization

One consequence that is linked to the experience of child abuse and insecure attachment is ongoing victimisation into adulthood. Within the literature, the experience of abuse uncovered as an adult takes the form of IPV and subsequent relationship distress and ongoing life stress (Weinfield et al. 2004). This was equivalent across both men and women. For instance, Godbout et al. (2009) discovered that 27% of their sample who had experienced CPA reported physical IPV and 83% reported psychological IPV. In addition, Alexander (2009) found that 90% of women with an unresolved attachment style due to child abuse were more likely to suffer multiple victimisations in adulthood.

Psychiatric Treatment Impact

In psychiatric populations, insecure attachment style appears to impact on two distinct areas. The first is an association with increased likelihood to disengage from mental health services and the second is length of stay in psychiatric in-patient care. For example, Gumley et al. (2014) literature review of 21 studies on attachment and psychosis, identified attachment avoidance as associated with reduced likelihood to seek help for mental disorder ($r = -0.55$; $p < 0.01$). In addition, Ponizovsky et al. (2007) assessed an in-patient clinical sample of 30 men with schizophrenia and 30 healthy controls. They found those with avoidant attachment style (56.7% of sample) spend significantly longer in psychiatric hospital than those with secure attachment style ($t = 2.29$; $p < 0.05$; $r = 0.20$). Conversely, secure attachment is associated with better engagement in psychiatric treatment and treatment adherence than any of the insecure attachment styles (Ponizovsky et al. 2007). Although significant, the sample size is problematic and the study does not allow for influence of schizophrenia subtypes.

Suicidality

Increased suicidality is identified in the findings of three studies. For example, Kiesel et al. (2014) determined that suicidality is an evident consequence in youth with CSA history. Smith et al. (2011) found similar results, but with depression providing a significant contribution.

Likewise, Finzi et al. (2002) identified increased suicidality in physically abused children, alongside avoidant attachment style and depressive symptomatology. Their study assessed 114 children aged 6-12 years in three groups. Those with CSA history had the highest frequency of avoidant style (85.4%), with suicidality noted in 53.7%, compared to only 5.4% of neglected group and 5.7% of non-maltreated. The age of the children places the timeframe of the data within an immediacy of their trauma experience. This does not allow for development but could be useful if part of a follow-up study into adulthood.

Limitations

The goal of the chapter was to systematically review the literature on associations between childhood trauma, attachment and poor mental health. This was achieved by collating 42 studies dealing with some variant of this relationship. The literature was discussed in terms of three key questions, namely; is there an association, the nature of the association and the consequences of the association. A number of limitations require consideration, including difficulties with definitional, methodological, and theoretical concepts that can prove confusing and need navigating.

Definitional terms were a challenging area in the literature. An example is childhood trauma. Some use maltreatment, victimisation, abuse, trauma, adversity and so on. This can be difficult to compare like for like when studying the research. Emphasis can alter the perspective of the study if such trauma as a one-off victim of crime experience is given equal consideration as a victim of prolonged child sexual abuse. The terms do not appear to be culturally specific, but rather the preference of the lead researcher. This may also explain some of the lower correlations.

This also occurs with the concept of attachment. The terms for attachment style are different across all of the papers. This includes the use of standard and non-standard styles, unresolved attachment as a style in itself but added to other attachment styles in some papers. Some researchers use the three model typology presented by Ainsworth et al. (1978) and others use the four model typology presented by Bartholomew and Horowitz (1991). The standardization of language and in some cases, the measures used for attachment style is a challenge. Once

established, each term does correlate with an original definition provided in the four-model typology (see Appendix 2a).

Psychiatric diagnoses and the spectrum of varied terms used are another limitation. Some are stated using psychiatric diagnostic criteria from ICD-10 or DSM-V. Others prefer to consider the experience of psychological symptoms within the umbrella term of mental health problems. This is mainly straight forward with the use of validated rating scales to determine level of mental health difficulty within clinical terms. What can provide more of a challenge is terminology such as symptomatology. There is rarely a definition of what this means in terms of severity, frequency, duration and so on.

Methodological issues are apparent across the literature. There are variations in data collection methods and tools used. For example, data collection is undertaken via two explicit routes. One is through a variety of questionnaire-based methods and the other is specific attachment scales via structured interview. This creates difficulty in making comparisons, with the scales more robust than the questionnaires. With quantitative methodology favoured, an understanding of the subject-matter is limited. There is also over-reliance on cross-sectional survey design, raising concern for vulnerability to common method variance (Lindell and Whitney 2001).

Ways Forward

The presence of childhood trauma appears to influence the development of insecure attachment and subsequent adult outcomes, such as mental health and wider functioning. For instance, the development of an insecure attachment can hinder social progression to engage with others, trust, allow intimacy, socialise for self worth and self preservation. Social functioning and all its human necessities are restricted or even lost. The person is portrayed as inadequate, needy, and often rejected by the social world or rejecting of the social world.

To move forward from the discoveries in the literature there must be a determination to enhance the narrative of such experience. For example, future research must take into account what it feels like to suffer childhood trauma. It must determine an understanding of the trajectory of individuals who navigate such traumatic lives, the impact of which is considered

in the research but lacking any insight. Concerns for the outcomes of childhood trauma require further consideration. As determined above, individuals are beset with the influence of early onset mental health problems, increased symptom severity, treatment compliance issues, and disengagement from services. In addition, their inability to function in the social world has a negative impact on forming close relationships, accessing support networks, and seeking help.

There are fundamental issues identified within this specific population that can be better understood through qualitative inquiry. It is necessary to access the voice of the person experiencing these human traumas, developing insecure attachment style and experiencing poor mental health outcomes. Evidence from the positivist paradigm details a relationship, but qualitative methodology will enhance the narrative and illuminate their lived experience.

Conclusion

This systematic literature review was conducted to consider research evidence available for the association between childhood trauma, attachment style and adult mental health problems. The strict guidelines for systematically accessing, scrutinising and accepting literature was undertaken. All studies that made final inclusion met quality assessment criteria to further enhance rigour. Several aspects emerged, including a focus on whether there is an association established in the literature with regards to trauma, attachment and mental health. This was clearly identified within the quantitative data across all research studies reviewed. Secondly, the nature of the association included a connection with age of onset, specificity of experience and ongoing trauma and attachment style across the lifecourse. The third section considered the impact on personal development, social relationships and ongoing vulnerability to increased risk of trauma. The limitations of the literature are detailed in recognition of the challenge with language and methodology that appears evident in this field. Finally, this chapter has presented ways forward that are succinct and offer a determination to consider the topic further, to widen the debate and promote a platform for the voices of those with lived experience. The next section of the thesis is Methodology.

PART TWO

METHODOLOGY

Part One of this study presented a systematic review of literature which has considered the influence of childhood trauma on mental health and attachment relationship outcomes. Part Two will provide a detailed critical assessment of the research design and methods employed in the current study which aims to investigate social attachment experiences of adults with mental health problems and a history of childhood trauma.

Part Two is organised around six succinct chapters. Chapter 4 presents the epistemological underpinnings of the study and critically justifies employing Interpretive Phenomenological Analysis (IPA). Chapter 5 discusses the sampling strategy used with a particular focus on addressing issues associated with establishing sample homogeneity and access. Chapter 6 provides details on the interview guide and discusses the relevance of using face-to-face interviews as an appropriate method of data collection. Chapter 7 discusses the analysis aspect of IPA employed in order to draw together and make sense of the findings. Chapter 8 recognises the deeply sensitive nature of the research subject matter and provides consideration of the ethical safeguards established. Finally, Chapter 9 takes the opportunity to provide a short reflective account of my research experiences; an important consideration when acknowledging the hermeneutic nature of studying such a sensitive subject as childhood trauma.

Chapter 4

Research Design

The aim of the present study is to investigate experiences of childhood trauma and its subsequent impact on social relationships. Previous research has failed to address this issue directly and has often been carried out within a positivist framework which has employed quantitative measures in order to understand childhood trauma, attachment styles and forms of mental health outcomes.

This chapter explores the phenomenological design underpinning the study, and is organised around three key sections: Section 1 justifies the epistemological position of the researcher in adopting an interpretivist paradigm. Section 2 presents a critical overview of the research design for this study (interpretative phenomenological analysis) and why it is preferable to others such as grounded theory and thematic analysis. Section 3 discusses some important methodological aspects of IPA that were central to the collection and interpretation of the findings.

Epistemological Position of the Study

Epistemology is the theory of what we can know (Kalof et al. 2008). It is concerned with the relationship between the inquirer and those being studied. The inquirer adopts an epistemological position in-keeping with their perspective of the relationship and what can be known. The two opposing paradigms of positivist and interpretivist provide the choice. Each paradigm is rooted in the philosophical consideration of what is regarded as acceptable knowledge in a discipline (Denscombe 2014).

The positivist paradigm draws on the assumption that within natural science, nature is basically ordered and regular and an objective reality exists independent of human observation (Polit and Beck 2012). The interpretivist paradigm adopted for the purpose of the present study, provides a contrasting subjective position. For example, Weber (1949) referred to the interpretivist approach as *Verstehen* (meaning: understanding) (Bryman 2008). He believed that the purpose is to 'seek interpretive understanding of social action' (Weber 1964:

88). Other theorists such as Schutz (1979: 35) added that the theoretical constructs of the social world must be compatible with the 'constructs of everyday life'.

Interpretivist research seeks truth but only as a subjective experience that is collectively shared by homogeneous groups of people who have a shared experience of a similar event, such as childhood trauma. In order to achieve this in the present study, knowledge is obtained by appreciating and interpreting actual lived experiences of participants (Denscombe 2014). As a consequence, any research method employed must appreciate the importance of both hermeneutics (theory of interpretation) and phenomenology (the essence of a phenomenon as experienced by people and what it means to them).

Research Design for the Study

Within the spirit of interpretivist epistemology an important research design has recently been formulated referred to as interpretative phenomenological analysis (IPA) (Smith 1996). IPA is described by Smith et al. (2009: 1) as 'a qualitative research approach committed to the examination of how people make sense of their major life experiences'. Its popularity amongst qualitative researchers has grown over recent years. It is believed to be the most widely known qualitative approach to phenomenological psychology today (Langdrige 2007).

Overview of IPA

The aims of IPA fit well with the aims of the present study. For example, IPA focuses on exploring in detail participant personal lived experience and how they make sense of that personal experience. This identifies commitment to the 'I' and the 'P' of IPA, as detailed by Larkin et al. (2006). It is, a phenomenological (P) requirement to understand and 'give voice' to participant concerns; and the interpretative (I) requirement to contextualise and 'make sense' of these concerns from a psychological perspective. For this reason IPA provides a compatible research design suited to understanding the experience of childhood trauma and its influence on attachment relationships for people with mental health problems.

The application of IPA can be identified through three broad characteristic features: ideographic, inductive and interrogative (Smith 2004). In being ideographic, IPA is committed to the detailed examination of the particular case (Smith et al. 2009). It seeks to discover how

a given person, in a given context, makes sense of a given phenomenon (Cohen et al. 2007). The research process involves both induction and deduction. However, for IPA, the inductive stance is in the foreground allowing for unanticipated topics or themes to emerge (Smith 2004). Finally, the IPA researcher employs an empathic but critical hermeneutic process to produce an interrogative account based on experience (Wagstaff et al. 2014).

Other Research Designs

Good qualitative work seeks detailed, complex interpretations of socially and historically located phenomena (Thorne 2000). It involves gaining understanding, meaning and interpretation (Smith et al. 1995). This can be achieved through a range of available research designs and options for qualitative data analysis. In essence, the analysis should reflect the nature of the study. With the interpretivist paradigm adopted, the focus is on the level of interpretation employed. This is identified by Plummer (1983: 113) as a, 'continuum of researcher contamination'. At one end of the continuum is theoretical analysis which takes no account of subjective experience through to simple editing of life accounts with no explicit interpretation. For the current study, the focus is on striking a balance. The research design would include a level of interpretation that goes beyond simple reports (Kalof et al. 2008: 148), but maintains the integrity of the data (Green and Thorogood 2009).

Options available include less interpretative methods of analysis such as descriptive phenomenology which interprets the data through a descriptive structure of the meaning (Giorgi 1985). Likewise, a narrative analysis such as thematic analysis (Joffe 2012) provides interpretation of the data through emerging themes. Alternatively, methods such as grounded theory focus on more interpretative processes (Glaser and Strauss 1967). Although some aspects of these methods of analysis appear similar to the philosophy of IPA, there are differences that are not as compatible with the emphasis of the study at first glance. To illustrate this, each will be explored in more detail.

Descriptive Phenomenology

Phenomenological research considers the essence of a phenomenon as experienced by people and what it means to them (Polit and Beck 2012). The search for the essence is therefore essential to phenomenology. The purpose is to explicate the essence of lived experience of a

phenomenon through its identification and accurate description of everyday lived experience (Rose et al. 1995).

Descriptive phenomenology (DP) is usually characterised as a way of seeing rather than a set of doctrines (Moran 2002). It is a design that is not concerned with how things actually are in reality, but rather concerned about how things are experienced (Gallagher 2012). For example, in this approach, phenomena are real because they are treated as real; whether they really exist objectively is irrelevant. This means that the essence of objects can only be understood through studying subjective perceptions of those objects (Green and Thorogood 2009: 14). According to Berrios (1989) the process strives to capture experiential essences which are but higher forms of knowledge. The researcher then reconstructs reality on a firmer footing. Reward for such endeavour is the moments of seeing meaning or 'in-seeing' into the heart of things (Van Manen 2007).

Giorgi (2012) states that the researcher must concentrate on what are 'given' as a phenomenon and everything that is said about the phenomenon is based upon what is 'given'. In so doing, there is a need to describe the 'given' precisely, nothing added or subtracted (Giorgi 2012). A feature that helps this process is bracketing, whereby the researcher sheds all prior knowledge in order to grasp the lived experiences of those being studied. The researcher must 'bracket off' prior conceptualisations, prejudices and theories by which the phenomenon is understood (Green and Thorogood: 14). Husserl refers to this as epoché (a Greek word meaning suspension of belief) (Gallagher 2012).

Descriptive phenomenology provides a formula that is attractive. It allows the researcher scope for detachment, rather than accepting prior knowledge. It is an opportunity to present the findings in their purest form, as meaning units of description. There is an element of interpretation involved, but not to the level of IPA. Description of the lived experience is restricted to the data and so, does not go far enough for this study. IPA has latitude to explore data more deeply and extrapolate beyond the text (Guest et al. 2011). This presents an exciting challenge to interpret the language, context and phenomenon further than the descriptive text.

Grounded theory

Grounded theory (GT) focuses on analysing the actual production of meanings used by social actors (participants) in real settings (Gephart, 2004: 457). However, the process of achieving this relies on two key concepts that raise concern. The first is constant comparison through an iterative process of simultaneous sampling, data collection and analysis (Polit and Beck 2012; Kalof et al. 2008). Researchers collect data through a range of mediums such as unstructured interview, field notes, photographs, news articles and other information that clarifies the concepts (Streubert and Carpenter 2011). Participants could also compile diaries about their past experience, be observed in interaction with others or interview others about them.

The second is theoretical sampling in which decisions about which data should be collected next are determined by the theory that is being constructed (Suddaby 2006). This involves access to a diverse sample of people with differing experience of the phenomenon. As the stages of GT are repeated, new participants are added until no new categories emerge (theoretical saturation). Typically, an average sample size ranges from 10-60 persons (Starks and Brown Trinidad 2007). The overall focus is to develop theoretical insights (Green and Thorogood 2009) and determine new formal theory (Bryman 2008).

Both aspects described above are limitations that make IPA more attractive to the researcher. For example, there is no way of knowing how long it can take to reach saturation (Green and Thorogood 2009). This places concern on time-constraints for remaining true to the essence of the design and often requires work on a considerable scale (Smith et al. 2009). In addition, recruitment raises concern for needing to add more participants in an attempt to reach saturation. The sensitive nature of childhood trauma and the unpredictable nature of participant health, render this aspect of the process an unnecessary risk.

Thematic analysis

Thematic Analysis (TA) is a method using constant comparison analysis (Thorne 2000) for identifying patterns of meaning in a dataset (Braun and Clarke 2006). It focuses on creating themes from the data that is either manifest or latent. This is achieved through the deduction of latent meanings underpinning sets of manifest themes. Although this requires interpretation, TA always remains faithful to the body of data (Joffe and Yardley 2004). That is, interpretations are only influenced by participant generated issues (Alhojailan 2012).

Thematic Analysis is both a systematic and transparent qualitative method that holds the prevalence of themes as important without sacrificing the depth of analysis (Joffe 2012). It is a flexible method that provides an opportunity to understand the potential of any issue more widely (Marks and Yardley 2004). This is mainly due to the researcher having no requirements for a specific theory or sampling. For example, TA can be underpinned by a range of theories, including phenomenology. In addition, sampling can allow for and indeed favour larger data sets.

Thematic Analysis has recently been acknowledged as a method in its own right (Joffe 2012), but remains only a method and lacks published text that offers guidance on, for example, aspects such as sample size (Fugard and Potts 2015). Rather, elements of TA are found in numerous generic qualitative books (Guest et al. 2011). On the other hand, IPA provides an entire theoretically informed framework for conducting research which incorporates TA (Benner 1994). Similar to descriptive phenomenology, TA is also restricted to the data. IPA is preferred for its freedom to explore data more deeply and interpret beyond description.

Descriptive phenomenology, grounded theory and thematic analysis do not appear to fit the remit of this study. As discussed, GT is data-driven to derive formal theory, rather than participant-driven. Whereas, DP and TA are flexible methods for identifying patterns of meaning in the data but do not go beyond the text. GT, DP and TA are therefore discounted in favour of IPA and its suitability to the study. It focuses on understanding experience and prioritising participant voice. As such, it takes the data analysis beyond description, thematic content and theory generation, to an interpretation that can provide insights and explanation of the lived experience.

Application of Interpretative Phenomenological Analysis (IPA)

Choosing IPA is not a matter of choosing 'the right tool for the job', but rather a question of identifying 'what the job is' (Smith et al. 2009: 43). The prime reason for choosing IPA is because it is consistent with the epistemological position of the research question for this study. Both the interpretative and phenomenological aspects of IPA are 'right for the job'; the focus of which is interpretation of the impact childhood trauma has on the social attachments

of people with mental health problems. As such, IPA is more to do with what humans experience rather than what they consciously know (Soloman 1987).

It is also important to the researcher that IPA is philosophically underpinned by Heideggerian hermeneutic phenomenology (Thompson 1990). It goes beyond the mere description of core themes to look for meaning embedded in common life practices. For example, understanding phenomenon comes from 'being-in-the-world'. This is what Heidegger termed 'Dasein', translated literally as 'there-being' (Mulhall 2005). It is the existence, the presence, the 'being there', peculiar to human beings (Heidegger 1953/2010). It is Dasein that will illuminate the social experience of participants in the present study.

Although one cannot truly access the 'life world' of another, IPA researchers use their own knowledge of the world to assist in interpreting the world of another (Clarke 2009). This is an important factor here, in allowing for the clinical experience of the researcher and any preconceptions of the subject, the setting and the population. This is what Gadamer termed 'fusion of horizons' to refer to the merging of the interpretation of an experience with researcher preconceptions (Langdrige, 2007). He believed, 'in being part of history, it is not possible to step outside of history to look at the past objectively' (Gadamer 1993). This seems a sensible position for the study.

Methods identified by Smith et al. (2009) for achieving a good IPA study are explored here:

Idiographic

IPA is strongly idiographic, beginning with a detailed examination of one case until some degree of closure is achieved. Then move to a detailed analysis of the second case; and so on through the body of cases. Warnock (1987) makes the point of delving deeper into the particular to come closer to the universal. Only when closure has been achieved with each case is there an attempt to conduct a cross-case analysis as the tables of themes for each individual case are interrogated for convergence and divergence (Smith 2004). This level of detailed analysis is only possible on a small sample. It honours the narrative of each individual who share their history of childhood trauma. This is important factor for the integrity of the research.

Inductive

IPA researchers are flexible enough to allow themes to emerge during analysis that were not anticipated. Smith (1999) provides an example of inductive IPA. His study explored female identity development during transition to motherhood. The focus was on the individual, so no questions about relationships. However, without exception, all of the women brought their relationships into the discussions. The research process involves interplay between inductive and deductive but, IPA has inductive stance in the foreground (Smith et al. 2009). For the present research, previous clinical knowledge and preconceptions should not restrict openness to unexpected new findings.

Interrogative

A key aim of IPA is to make a contribution to psychology through interrogating existing research. While IPA typically involves an in-depth analysis of a set of case studies, the results of the analysis do not stand on their own, but rather are subsequently discussed in relation to psychological literature. An example: Flowers et al. (1997) study of attitude to safe sex with gay men, found that love was the reason for unprotected sex and commitment to the partner. This was at odds with the literature which stated it was due to selfish privileging of somatic pleasure. A key point for the present study and commitment to participants will be dissemination of the findings in psychology literature.

Levels of Interpretation

IPA moves beyond the text to a more interpretative and psychological level. The focus is to listen and understand the individual voice of the participant and to trust the response through interpretation (Smith et al. 2009). For instance, IPA uses 'double hermeneutics' (Smith and Osborn 2008: 53), where the researcher is making sense of the participant, who is making sense of their experience (Smith et al. 2009: 35). While participant perspective is emphasised, researcher interpretation of the data is a crucial element in the development of a coherent, themed investigation (Biggerstaff and Thompson 2008). To illuminate the process, an extract exploring three levels of interpretation is provided in Table 4.1, from a study cited in Smith (2004: 44).

Table 4.1: Three Levels of Interpretation.

"I just think I'm the fittest. I used to work like a horse and thought I was the strongest and then all of a sudden it's just cut down and I can't do half of what I used to" (Linda).

1. On the first level, Linda is engaged in social comparison with her sisters, as part of a complex set of social comparisons Linda makes during the interview.
2. The next level, one can zoom in on the use of metaphor. Linda compares herself with a horse – to exaggerate the strength she once had and emphasise how weak she feels now. Also, being 'cut-down' is a metaphor that considers grass being cut to size or a tree being felled.
3. To push the analysis further still, Linda begins in the present tense, referring to herself now... 'I'm the fittest'. Surely she means, 'I used to be'. She then slips into past tense, 'I thought'... referring to the past strength.

Linda is acknowledging she has lost a previous identity, which is replaced by a more vulnerable self. She could be struggling between being taken over by the 'New Self' defined by chronic pain and clinging on to an 'Old Self' in spite of that pain.

Source: Smith (2004)

The level of depth in the interpretation is an important feature of IPA. It provides additional insights of the lived experience of the individual that can be considered against the wider phenomenon. Indeed, all methods of IPA are a useful guide for how findings are collected and interpreted. However, Smith (2004) believes good qualitative research cannot be conducted by following a cookbook. All guidance offered should be considered for adaptation and developed. Quality of the research outcome is identified in the process of personal analytical work completed at each stage (Smith 2004). Smith et al. (2009: 55) reminds the novice researcher that, 'there is no 'perfect' data collection event, no versions of events which is 'the truth', just aiming to understand participants as best as possible'.

Whilst analysis can be achieved through adherence to IPA processes above, it can also be considered through other data analysis options. The guidelines for all qualitative data analysis are generally broad (Okely 1994), leaving scope for flexibility and creativity. Within IPA this enables options in the method of coding and theme emergence. Traditional paper and scissors can be used to create a manual overview of theme identity. Equally, computer software can assist with the demands of a large data set. For example, there are a number of coding

packages available, but the one most utilised in qualitative analysis is NVivo. Although a consideration, the coding format is too restrictive for the flexibility necessary for IPA. As such, a standardized IPA approach will be used as described above.

Conclusion

IPA offers an established, systematic, and phenomenologically focused approach, committed to understanding the first person perspective from the third person position (Larkin et al. 2011). It involves recognition of the researcher in the construction and analysis of data. It is a reflexive approach that can be beneficial to a novice researcher. IPA means to provide a complete in-depth account of a phenomenon that privileges the individual and their experience. With regards to the present study, all aspects discussed provide confidence as to the purpose and integrity of the inquiry to be undertaken with a vulnerable population. IPA is therefore selected on the basis of fulfilling the primary objective of understanding the impact of childhood trauma on the personal and social world of people with mental health problems. The chapter that follows will discuss the sampling method employed for this study.

Chapter 5

Sampling Design

Sampling must be theoretically consistent with the qualitative paradigm in general (Higginbottom 2004) and with the orientation of IPA in particular (Smith et al. 2009). The researcher must develop a sampling design capable of answering the research question, identifying specific sites and subjects, and securing their participation in the study (Devers and Frankel 2000). In particular, sampling in phenomenology requires that participants have experienced the phenomenon under investigation and are willing to articulate the experience (Streubert and Carpenter 2011).

Inadequate description of the sampling strategy can be an impediment to assessing whether the strategy was productive (Polit and Beck 2012). For this reason a sampling framework developed by Robinson (2014) will provide context to illustrate how sampling was achieved. The framework has four 'pan-paradigmatic' points: (1) setting a sample universe, (2) selecting a sample size, (3) devising a sample strategy, and (4) sample sourcing. Addressing these sampling issues in a comprehensive manner will increase the validity of the study (Yardley 2000).

Sampling Universe

Setting a sample universe is the totality of persons for which cases may legitimately be sampled in an interview study (Fink 1995). Sampling plays an important role in defining the study aims and focus (Devers and Frankel 2000). The more a sample is clearly and explicitly described improves validity and credibility (Robinson 2014; Yardley 2000). Within the present study, the sample is focused on adults with mental health problems who have a history of childhood trauma. This sample is as homogeneous as possible (Clarke 2009), through their shared events, incidents and experience (Sandelowski 1995).

The extent of sample homogeneity is influenced by theoretical and practical factors. Theoretically, research designs such as IPA have a preference for homogenous samples due to

a phenomenological focus. Practically, issues can arise with gaining access to a sample from a particular population. This was a recognised concern here due to possible issues of access to such a vulnerable population. It was hoped that the clinical background of the researcher may assist in overcoming any barriers.

To determine the specific profile of eligibility, an inclusion and exclusion criteria is applied. In IPA, participants are specifically selected on the basis that they can grant access to their perspective on the phenomena under study (Smith et al. 2009). To gain this perspective, the participant would firstly have a formally diagnosed mental health problem. This was not restricted to any specific category but include disorders such as anxiety (e.g. generalized anxiety disorder), depressive (e.g. major depressive disorder), psychotic (e.g. schizophrenia), and personality (e.g. borderline personality disorder). Secondly, the participant will have experienced intra-familial childhood trauma. This may include one or more experiences of physical, sexual, emotional abuse, or neglect, domestic abuse, traumatic illness or parental death. It was not expected to be formally recorded but based on participant interpretation. Finally, the participant would be over the age of 18 years.

Exclusion was mainly based on not fulfilling the inclusion criteria. However, in view of seeking participants with mental health problems, consideration was given to their needs. For instance, should an individual be too unwell to participate they may be rescheduled or excluded. This would be based on participant perspective, researcher concern and advice from the local mental health charity. However, all participants that came forward to be involved in the study met the inclusion criteria. No individual required exclusion.

Sample Size

The ideographic emphasis of IPA requires reduced numbers and manageable amounts of data (Clarke 2009). However, a key issue in phenomenology is to generate enough in-depth data to illuminate the patterns, categories and dimensions of the phenomenon under study (Polit and Beck 2012). In IPA, enough detail can be elicited from a few participants. This enables the individual's voice to be located within the study and for intensive analysis of each case (Robinson 2014). It does also rely on participants being good informants, able to reflect on their experiences and communicate effectively to provide quality data (Polit and Beck 2012).

Smith and Osborn (2008) believe the sample size depends on several factors. These include commitment to the case study level of analysis, the richness of the individual cases, and the constraints one is operating under. As a result, IPA studies have been conducted with one, four, nine, fifteen and more participants. Smith et al. (2009) states it is difficult to give a number for PhD studies. Between five-ten participants is a typical amount for dedication to depth and sufficient numbers for similarity and difference, convergence and divergence (Smith 2004). Exceeding these numbers may lead to being overwhelmed by the vast amount of data generated (Smith and Osborn 2008).

The sample size for this study is fifteen participants. The number is larger than most, but not unusual in health-related IPA studies; see Dickson et al. (2007). Due to sensitivity of the topic (childhood trauma) and flexibility required for the participants (mental health problems), the researcher was confident fifteen would ensure an adequate number for study attrition. For example, participants would have the opportunity to participate but also withdraw at any time. The subject is deeply personal, sensitive and intimate. Participants may be more reluctant to disclose and subsequently wish to stop involvement or retract any information imparted. This was a very real concern with this study, but no issues of withdrawal occurred and participants disclosed information they were comfortable to share. Although the quality and depth of interviews differed it was important to give all participants a voice and so no interviews were excluded either. The sample size remained fifteen but was manageable within the PhD time-frame for intensive analysis of each case, without being subsumed into the larger whole (Robinson and Smith 2010).

Sampling Strategy

There is a range of sampling strategies available to the researcher but in general, most qualitative research use purposive sampling. This is applicable to IPA and the present study, where purposive sampling is used in order to find a more closely defined homogeneous group for whom the research question will be significant (Smith and Osborn 2008). Therefore, ensuring all participants represented in the sample are included for their experience of mental health problems and history of childhood trauma (Mason 2002).

According to Patton (2002) the power of purposive sampling lies in selecting the information-rich cases, for which one can learn a great deal about issues of central importance to the research. As such, participants were selected on the basis of likelihood to provide appropriate and useful data (Green and Thorogood 2009). This required selecting people who were judged to be subjectively typical of the population (Polit and Beck 2012). In addition, purposive sampling is helpful in selecting people who are expert in knowledge of the subject. For the purpose of this study, the sample is perceived to be expert by experience.

Sample Sourcing

Once the above has been negotiated and achieved the researcher must source participants from the real world (Robinson 2014). This critical step requires the selection of settings and persons with high potential for information richness, to confirm, enrich and challenge the understanding (Polit and Beck 2012). Additionally, a variety of skills are necessary from the researcher at this stage of the process, including organisational, sensitivity, ethical consideration and so on. For instance, potential participants require study information, expectation of their role, clarification of confidentiality and any further information that may assist a decision to participate.

Research Sites

For this study, approaching mental health charities for recruitment of participants appeared obvious to the researcher. The charities provided several benefits for the study and potential participants. For example, opportunity to engage individuals who meet study criteria, familiarity of venue, support if required, separate from dominant statutory mental health services. Participants were therefore accessed from local mental health charities: MIND, Rethink Mental Illness, Making Space and Actively Influencing Mental Health Services (AIMHS).

Contact was made with the regional offices of the four mental health charities. Meetings were arranged with regional managers to discuss the research study. Following consultation, research discussion, ethical approval, amendment to study information, each local charity supported the study. This enabled access to a homogeneous group of adults with mental health problems and potential childhood trauma history. The purpose was to access people who attend adult mental health support groups, activities and social events.

Access

The next stage was to secure permission for access from local managers. This person may be termed the recruitment gatekeeper (Green and Thorogood 2009). Ideally, a gatekeeper can be turned into a research champion within the organisation, who will publicise the study and encourage participation (Robinson 2014). In so doing, gatekeepers vouch for the researcher and credibility of the research study itself (Devers and Frankel 2000; Yardley 2000).

Fortunately, this was established early on with each senior manager in each locality.

Access was achieved during the summer of 2012. Several opportunities for recruitment were provided by each charity across a county-wide radius. For example, charities allowed the placing of study recruitment posters on notice boards (see Appendix 5a). Also, the availability of study information sheets with contact details (see Appendix 5b). Finally, being invited to address various weekly or monthly meetings was most beneficial for initial rapport-building (Dickson-Swift et al. 2007). Meetings included drop-in, group, educational and general gatherings. The size of the groups addressed ranged from four people up to 100 people, with an average of 25 per talk. The majority of participants were recruited via the meetings.

Participation

Individuals who consent to be involved in interviews may be different to those that do not, leading to what Costigan and Cox (2011) call self-selection bias. For example, volunteering for extensive intimate self-disclosure can lead to a sample containing individuals more open, patient and interested in the topic than the general sample universe (Robinson 2014).

However, Collier and Mahoney (1999) believe this is an issue for any kind of study and one that should not be overstated as a problem. Essentially, the sample is defined by who is prepared to be included in it (Smith and Osborn 2008). In the present study, the researcher was pleased to gain participants who were open to sharing their experience.

Participation in this study would not be rewarded by incentives such as travel or child care expenses, payment, or payment in kind (Green and Thorogood 2009: 141). Although incentives improve recruitment and retention (Yancey et al. 2006) they also add motivation to produce what Robinson (2014) calls 'dodgy data'. With no incentives, participation was built on trust and minimising disruption and expense. This was achieved by meeting at the local mental

health charity on days convenient for the participant. This was preferable to the researcher for safeguarding both parties in a staffed environment at a mutual venue.

Relationship

It is important to note that all qualitative research requires the development, maintenance and eventual closure of relationships with research subjects and sites (Devers and Frankel 2000). Effective sampling improves the rigour of the research (Yardley 2000). For this reason, it was important to have a participant information sheet with researcher contact details (see Appendix 5b) and an interview completion sheet regarding the end of involvement (see Appendix 5c). Discussions also took place with regards time-frame for engagement, expectation of participant and site and realistic prediction for completed written report.

When participants came forward, contact details were exchanged and follow-up contact made within days of meeting. All correspondence and dealings for participation in the study, discussion about the study or researcher, scheduling of interview, actual interview and any subsequent contact was only ever conducted directly between researcher and participant (Ritchie et al. 2003). This was to build rapport and increase confidentiality by separating the mental health charity from any influence on the relationship. It also provided an element of participant control to contact, and hopefully feel heard, respected, and safe within the research process (Wilson and Neville 2009).

Participants

In total, fifteen participants took part in the study, with 9 women and 6 men. All defined themselves as white British. Table 5.1 provides a brief overview of the demographic information shared by participants. The information was given in confidence and within the interview process, rather than a demographic questionnaire. The terms used are those supplied by the participants themselves. To ensure confidentiality, each participant was allocated a pseudonym, chosen via their corresponding number being aligned to the most popular boys and girls names according to the Office for National Statistics (ONS) (2015).

Table 5.1: Demographic Information of Participants

*Name	Gen	Age	Mental Health problem	Physical Health problem	Home	Education	Income	Status
Isla	F	58	Depression	Migraine/IBS	Flat	School/0	DLA	Divorced
Jacob	M	62	Depression	Diabetes	Flat	school	Pension	Single
Ava	F	47	Borderline	DVT	House	Masters	DLA	Divorced
Poppy	F	47	Depression	Epilepsy	Bedsit	school/0	DLA	Widow
Oscar	M	47	Schizophrenia	No	Bedsit	school/0	DLA	Single
Amelia	F	43	Borderline	Fibromyalgia	House	school/0	DLA/Vol	Divorced
Sophia	F	51	Depression	IBS	House	School/0	DLA	Single
William	M	51	Schizophrenia	Pain	Flat	school/0	DLA	Single
Noah	M	62	Schizophrenia	Pain	Flat	school/0	Pension	Single
James	M	61	Psychosis	MS/IBS	Flat	Degree	DLA	Single
Evie	F	58	Depression	High BP	House	school	DLA/Vol	Divorced
Ella	F	42	Borderline	Fibromyalgia	Flat	Degree	DLA/Vol	Single
Scarlett	F	22	Depression	Asthma	Shared	school	Student	Single
Isabelle	F	48	Bi-Polar	No	Flat	school	HC work	Married
Freddie	M	37	Depression	No	Shared	Degree	DLA/Vol	Single

Key:
 BP = Blood Pressure
 IBS = Irritable Bowel Syndrome
 DVT = Deep Vein Thrombosis
 MS = Multiple Sclerosis
 HC = Healthcare
 School/0 = Left school with no qualifications
 DLA = Disability Living Allowance
 Vol = Voluntary Work

*All names provided are pseudonyms.

All fifteen participants who came forward remained throughout the research process. At no point did any participant express any wish to withdraw. In fact, the opposite occurred, with expressions of gratitude for being able to share their story and place it on record. Many believed this will assist in helping others to tell their story. In addition, a number believed the information shared would help make a difference to mental health service provision.

IPA aims to maintain the participant as central to the research process and give voice to their lived experience. In maintaining the ideographic focus of IPA, a more informative introduction of each participant can be found in Appendix 3. It provides a detailed pen portrait (Finlay 2014,

Nicholson 2001) that helps to recognise participants as real people (Moustaka 1994). Each pen portrait details background context, an outline of the interview experience and a representative quote from their unique contribution.

Conclusion

This chapter has provided a detailed and comprehensive overview of the sampling design employed for the present study. Consideration has been given to how to recruit, who to recruit and where to recruit from. Each stage was carefully negotiated and successfully completed. The next chapter will identify the process of data collection.

Chapter 6

Method of Data Collection

The principal method of data collection in IPA is a semi-structured interview, using an interview guide based on the original research questions (Smith 2011). This important stage can be broadly categorised into two main areas; namely, 1. Materials: focused on the use of documentation (interview guide, field notes). 2. Procedure: focused on the process of undertaking data collection. This includes planning the interview through to completion. It entails consideration of the venue, the interaction, the expectation, use of the interview guide, and the interview flow.

Materials

Interview Guide

An interview guide is strongly recommended in qualitative research and careful investment in their design is needed (Arthur and Nazroo 2003). It is an important document within the research process, identifying the objectives and process by which the research is conducted. Therefore, compiling a guide beforehand leads to a more focused approach to the study and anticipation of what might be covered or should be covered (Smith and Osborn 2008). The raw qualitative data needs to be captured and put into a format amenable to analysis (Devers and Frankel 2000). For this IPA study, the interview guide will form the basis for collecting data through topics associated with the phenomenon. The addition of field notes recorded at interview will assist in providing further context. Having thought this through in advance the researcher will be able to focus on the participant and what they say.

In accordance with IPA, a semi-structured interview format is preferred. Reasons include, allowing participants a voice, option to move into novel areas during discussion, and producing richer data (Smith and Osborn 2008). On the other hand, it reduces researcher control, takes longer to carry out and is harder to analyse (Smith and Osborn 2008). With this in mind, the interview guide needed to be especially able to provide a flexible platform that can be followed by both the researcher and the participant. The guide was therefore formatted as an

aide-memoire to comprise of sections with topics in bold font and a set of prompts underneath in standard font, as identified by Arthur and Nazroo (2003: 125). The number of prompts included was to promote confidence in the discussion and consistency with data collection.

Constructing an Interview Guide

IPA researchers require a flexible data collection instrument that follows Smith and Osborn (2008: 63) basic tips for construction. These include, questions being neutral rather than value-laden or leading; avoiding jargon by framing questions in a way that is familiar and comfortable; and using open-ended questions. Resources also influence the degree of structure or instrumentation, such as time, number of cases, existing subject knowledge (Devers and Frankel 2000). In addition, the order of data collection is an important consideration for when to approach certain subjects (Arthur and Nazroo 2003).

Engaging service user involvement is vitally important in helping inform the design of any communication materials to better suit participants, such as the interview guide (Auckland 2010). Involvement increases relevance and credibility of the research (Thompson et al. 2009), but is also challenging (Rose 2004). For example, it is preferable to conduct preparatory work for user involvement (Pollard and Evans 2013). This may entail the provision of training (Brett et al. 2010) and ensuring payment (Auckland 2010; MHRN 2013). In addition, service user involvement may present communication difficulties (Hewlett et al. 2006) and the possibility of sporadic illness (Pollard and Evans 2013). Such challenges are not insurmountable. However, this study is sensitive, driven by tightly defined deadlines and lacking resources such as payment. Instead of involvement in methodology, service users were consulted on the importance of the topic area at each study recruitment event. This valuable information assisted in formulating ideas for the construction of the interview guide.

Compiling the interview guide entailed identifying what topics should be present to specifically draw out answers regarding the phenomenon. It is also important to consider what is not worthy of attention. This helped determine the number and focus of the questions. Constant consultation was sought from supervision to ensure this was not an area left to chance or paid less attention than other aspects of the study. Several drafts were compiled, until sections were formulated that represented the research questions:

1. What was the nature of the childhood trauma experienced by participants?
2. What did participants consider to be the cause of their experiences of childhood trauma?
3. What coping and adaptation strategies (if any) did participants employ?
4. What impact (if any) did their experiences of childhood trauma have on their adult lives?

One area for discussion that was additional to the specific research topics was how to obtain demographic information. It was decided that rather than have a separate form for the participant to complete, the information would form part of the first section of the interview guide. This would help commence the interview and meant that data was collected with ease via an audio-recorder, instead of written form. Consideration was given to the possibility of difficulties arising from participant anxiety on the day of interview, difficulty with writing and taking up valuable interview time.

An original interview guide (see Appendix 6a) was completed that comprised of a number of topics for open-ended questioning (Willig 2008). It was crafted over a period of weeks, combining a consideration for the sample population, study focus and research questions (Bryman 2008: 442). The topics are prominent enough to be direct and general enough to assist what is hoped to be an open-ended interview (Devers and Frankel 2000).

Testing the Interview Process

To ensure the interview process would run smoothly, two pre-test interviews were conducted with two colleagues. This has no benefit in providing any insights into a service user perspective, but did enable a review of the topics, the format, running order and delivery of questions (Smith et al. 2009). As a result, the guide was amended for the final time. This included reducing the number of main topics for increased distinction. Prompts were reduced in font size in order to recognise their use as an aide memoir rather than additional probes following each question. The experience provided practise for the interview process and additional knowledge. Firstly, use of the interview guide to loosely steer discussion (Arthur and Nazroo 2003). Secondly, adjust conversational style to the participant (Smith et al. 2009).

Field notes

The introduction of field notes accompanied the researcher for each interview. The purpose was to capture information outside of discussion. Because the interviews were audio-

recorded, it allowed room for the researcher to write down observations of non-verbal communication, attire, emotional presentation. The researcher also recorded the time, date, weather, venue, attendance, feelings and outcome of the meetings. These details added to the overall interview and were able to be used at the analytic stage, providing further insight and memory-jogging for certain aspects identified in the audio-recording. Information fleshed-out the audio to allow another layer of context.

Procedure

Place of Meeting

Place of meeting for majority of participants was a quiet room within the local mental health charity. This was arranged prior to gaining any participants. Each charity was accommodating in providing an adequate room. The minimum requirements were: privacy of room location, two easy chairs, a table for paperwork and recording device, sufficient time allocated for interview. There were various geographical locations to attend across the county. This meant liaison with different staff members. However, each regional manager was supportive of the study and so all needs were met. These mutual venues provided the perfect location for interviews. No home visits were intended or conducted due to risk factors associated with the nature and sensitivity of the study, vulnerable population and novice researcher (Green and Thorogood 2009).

Preparation

Preparation for fieldwork is essential, as many aspects of the process can go wrong. Awareness of contingencies and recognition of potential hurdles, emergencies, miscommunications is essential. The researcher was alert to the high possibility of issues arising with participants, staff and venues. Time-management, flexibility and communication were deemed the key to overcoming the majority of issues. As such, contact with participants and staff was maintained and available throughout engagement (Streubert and Carpenter 2011: 90). This fostered a confidence and value in all involved (May 2011: 143). Preparation demonstrates a dedication to the process of data collection to increase validity (Yardley 2000).

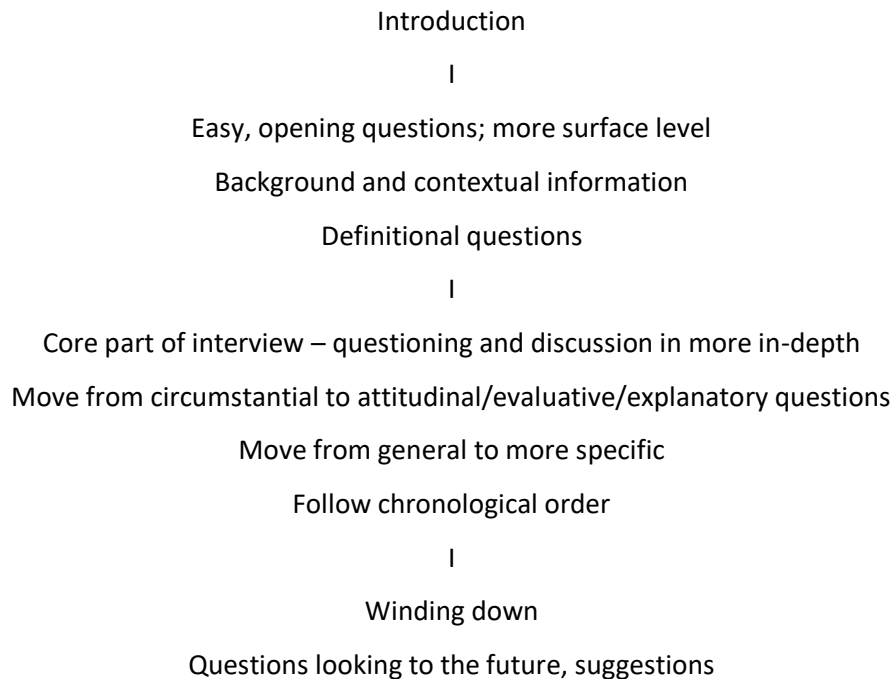
To minimise disruption and disappointment, the regional manager (gatekeeper) for each charity was contacted regarding the booking of an appropriate interview room. Then the

participant would be contacted to confirm attendance, date and time. Arrival at the venue would be ten minutes early. This extra time allowed for meeting staff and ensuring their support for the interview being uninterrupted (Smith and Osborn 2008). It also meant the room could be familiarised and prepared (Bryman 2008). Often a low table was available for study documentation and placement of recording device. This ensured favourable capture of both voices during interview. Finally a 'do not disturb' sign was placed on the door.

Once prepared, the participant could be invited in. Following introductions, the participant would read the information sheet (Appendix 5b) and sign the consent form (Appendix 5c). A final check of the Dictaphone for battery power, sufficient memory and placement on the table was made at this time. Permission is then sought with regards to writing during the interview. All agreed. A brief field journal was therefore maintained throughout the process from start to finish. This enabled a rich source of further information (see Appendix 6b). All such examples of interview documentation provide an audit trail to improve transparency (Carlson 2010).

Commencing the Interview

As identified in Figure 6.1: Arthur and Nazroo (2003) Stages of Discussion, the first part of the interview is focused on putting the participant at ease before moving to the interview guide. The researcher commenced with introductions and some small talk about weather, journey and then a rundown of the research process (Polit and Beck 2012). Then some relatively straight forward questions were asked regarding demographic information. Having been deliberately added to the interview guide they helped achieve a rapport (Green and Thorogood 2009: 112). Answers to demographic questions can be viewed in Table 5.1, Chapter 5.



Source: Arthur and Nazroo (2003).

Figure 6.1: Stages of Discussion in Interviews

Questions then moved to section 1: Background Context, with regards to health first and then childhood experience. What occurred with a number of participants is the commencement of their story of victimisation and childhood trauma. This was obviously accommodated within the semi-structured nature of the interview. It also afforded the researcher freedom to follow points raised. This flexibility had the advantage of allowing topics to be captured in greater detail to enrich the data (Reid et al. 2005). However, caution was shown not to guide the participant towards any particular assumptions regarding childhood trauma. Instead, the researcher facilitated the development and depth of their contribution through simple verbal encouragement, ‘mmm’, or, Smith et al. (2009) suggestion: ‘*could you tell more about that?*’

Interview Flow

The next stage is the core part of the interview. This is where the discussion moves from general to more specific questions. Ritchie et al. (2003) suggests this creates a less-threatening atmosphere for the participant. It was during this stage that the interview guide was only used to ensure the main topics were covered. Many prompts were unnecessary after a couple of interviews. The majority of participants would share information held within the prompt areas.

Very few needed probing. It became evident that it is more beneficial to remain with the participant and what they are saying, than rigidly follow the guide.

In addition, the sequence of the interview had to be flexible (Bryman 2008: 438). Some participants talked openly and engaged in many topic areas that were covered later in the interview guide. For instance, discussing the impact of victimisation before exploring what they considered were the causes. They did this of their own volition, whereas, a few required gentle questioning. It was therefore necessary to align with the participant and their momentum of expression (Smith et al. 2009). Interjecting to ask a set question would stop the flow. Therefore, the sequence was determined by participant disclosure rate and focus (May 2011). Responding to the dynamic of the interview enabled a more effective and balanced discussion (Arthur and Nazroo 2003).

Another area for consideration during the flow of the interview is data validation. This was achieved by clarifying responses, checking meaning, validating understanding; thus, improving the rigour of the study (Yardley 2000). As stated by Goldblatt et al. (2011), the commitment to do no harm leads to finding other ways of member checking, without 'forcing' participants into an ongoing relationship with the researcher, sensitive topic and study. Other options endorse their words such as clarifying meaning and language throughout the interview. This also included deciphering strong colloquial accents and understanding participants who had vocal restrictions due to medication side-effects. As such, it was necessary to check sayings or phrases to ensure the meaning was gained and recorded (Green and Thorogood 2009). Allowing time to express and gently confirming what was said appeared to be effective. Participant communication and researcher listening skills were critical factors throughout this process (Polit and Beck 2012).

Interview Completion

Towards the end of the interview it is important to wind down, so that participants can move away from any distressing feelings they may have experienced (Arthur and Nazroo 2003). The conversation turned to thanking the participant and discussing the time-frame for write-up. Often, it would turn to small talk again regarding journey, next place of visit and so on. Once the participant had left the room, the researcher would turn to the Dictaphone and check that

the interview had been saved. Then complete the recording of the encounter in the field notes.

Completion of the interview also included the timeframe with regards to ending. As participants are the expert in IPA studies, they must be allowed plenty of time to tell their story (Smith and Osborn 2008). The timeframe considered was for 45-60 minutes. However, the majority exceeded this time by 30 minutes to one hour. This emerged within the first interview. As a result, subsequent interviews were adapted for the potential extension of the time period. Most interviews exceeded the 60 minutes. This was a surprise that had not been anticipated, but was soon accommodated.

What also became clear, if not striking, was how comfortable each participant was in an interview environment, talking about personal information. This may be due to a range of factors such as their familiarity with the interview process within mental health care, the unthreatening environment conveyed by the researcher, or a combination of both. What this did is alert the researcher to the possibility of veering off course into a clinical scenario. Awareness of clinical techniques to intervene, suggest, and offer advice were quashed in favour of the eliciting nature of a phenomenological researcher.

Conclusion

Preparation of materials and procedure are a key factor in the successful negotiation of the data collection process. Two other aspects are essential in yielding the most in-depth, quality data. The first is to construct an interview guide with defined topics that combines consideration of the research questions, sample population, and study focus. The second is flexibility during the interview process to negotiate the topics at the participants pace and timing of disclosure. Both help the novice researcher maximise opportunities that will be of benefit at the data analysis stage (Smith et al. 2009), explored in the next chapter.

Chapter 7

Method of Data Analysis

The first aim of data analysis in IPA is achieving a highly intensive and detailed analysis of participant accounts. Then, to develop patterns of meaning that are reported in thematic form (Larkin et al. 2006). This chapter will therefore illustrate how the analysis was undertaken. Two main aspects form the basis for detailing this; namely, Transcription of the Interviews and the Six Stages of IPA Analysis, as identified by Smith et al. (2009). Finally, unilateral data analysis will be considered.

Transcription of the Interviews

Each interview was captured via a Dictaphone, recording what Smith and Osborn (2008) term, a 'full' account of the interview. In addition, a field journal was used to note behaviour, non-verbal communication, emotion and appearance. All fifteen interviews were transcribed by the researcher. This was beneficial for immersing in the data and the life world of each participant. It also added further context to the transcript. For example, as the researcher was present in each interview, aspects such as movement (eg: one participant produced a letter), or non-verbal communication (eg: one participant folded arms, another was tearful) were identified and placed in the text. This was aided by memory and cross-referencing the field journal. Other reasons included understanding vocal distinctions, such as regional accents and voice restrictions experienced by some participants, possibly as a result of psychotropic medication.

Often, the role of transcribing is passed to a professional transcription service. Whilst they provide timely, proficient transcripts, being used for a vulnerable sample raises a number of issues. For instance, the aspects discussed above would not have been recorded unless added after. Difficulties with accent, voice restriction, omissions, mistaking words and phrases are known problems for transcribers (DiCocco-Bloom and Crabtree 2006). Finally, two major issues for the present study include confidentiality and vicarious trauma. Although personal transcribing of fifteen in-depth interviews was a daunting task and time-consuming; it had definite benefits for the research validity and avoiding potential harm to a third-party.

Interviews were transcribed verbatim, adopting a detailed naturalised approach identified by Hutchby and Wooffitt (2008) rather than a denaturalised approach (Oliver et al. 2005). As such, the text was written in accordance with IPA, including laughs, pauses, and coughs (Smith and Osborn 2008). A complete picture of the voice and silence of each speaker in the interview was produced, becoming a co-constructed account for analysis (Rapley 2001). In addition, interviewer questions and verbal encouragement were also presented (Smith and Osborn 2008). Symbols used to illustrate transcript meanings are provided in Table 7.1.

Table 7.1: Transcript Symbols

Symbol	Meaning
(...)	Indecipherable narrative
...	Pause without words
UPPERCASE	Loud narrative
(long pause)	Longer pause without words
(coughs)	Description or comment on sounds
[Name]	Identifying name redacted
(laughs)	Form of laughter
Mmm	Verbal Encouragement

Transcribing all fifteen interviews also provided insight into the amount of time needed for analysis (Silverman 2006).

Stages of IPA Analysis

The essence of IPA lies in its analytic focus (Smith et al. 2009). Meticulous dedication through an iterative and inductive cycle enable this focus to be achieved (Smith 2007). Six steps of IPA data analysis have been identified in fulfilling the task. They are detailed in Table 7.2.

Table 7.2: Six Steps of IPA Analysis.

STAGE:	DESCRIPTION:
Step 1. Reading and Re-reading	Immerse oneself in the most interesting case first. Record recollections from the interview, then re-read.
Step 2. Initial Noting	Examine semantic content and language. Develop interpretative notes of participant's narrative
Step 3. Developing Emergent Themes	Map interrelationships, connections and patterns. Identify emergent themes in left margin.
Step 4. Searching for Connections across Emergent Themes	Cluster themes together to form a superordinate theme. Develop a structure of participants account. Create a table of emergent themes with page and line numbers and key words to illustrate each theme.
Step 5. Moving to the Next Case	Move to the next case and repeat steps 1-4. Allow new themes to emerge with each case. Continue for each subsequent case.
Step 6. Looking for Patterns across Cases	Lay out each table to consider connections across them. Consider similar and difference in themes. Reconfigure or relabeling themes as necessary. Create a table of themes across the sample.

Source: Smith et al. (2009)

The steps identified in Table 7.2 were adhered to in the present study. The analyst immersed in the data with meticulous attention to the essence of the lived experience of the participant (Smith et al. 2009). The first transcript chosen for analysis was Participant 1 Female (Code: PPS1F) or pseudonym: Amelia. The reasons centred on this being a most powerful and interesting case. Details of analysis are presented at each stage.

Step 1: Reading and Re-reading

Step 1 was conducted by reading through the text whilst listening to the audio-recording. This was a helpful method for re-engaging with the interview, but unnecessary for subsequent readings. First impressions mainly focused on the amount of rich data. This was not anticipated, even having been in the interview and transcribing it. As a result, analysis of this first case was quite overwhelming. The reality of reading and re-reading, ideas flowing, responsibility to the participant and connecting with the narrative created what Smith et al. (2009) call 'noise'. This was contained somewhat by recording first thoughts in a field journal

to return to later. What became obvious, is that time would be the biggest asset at this stage of the research.

Repeated reading allowed a structure to develop of how certain sections bind together. The interview is ordered chronologically but specific events that link together were not. Sometimes the same event came up a few times, whereas others were only mentioned once. This also created an awareness of how the participant moved from the general to the specific and back to the general. Brief notes and underlining of text commenced during this phase, merging both step 1 and 2 together after a couple of re-reads.

Step 2: Initial Noting

Here, the researcher began to examine the transcript for semantic content and language (Smith et al. 2009). No rules apply, as the researcher is not required to divide the data into meaning units or comment on anything specifically (Smith and Osborn 2008). This first transcript was very dense in valuable information. The depth was welcome but also required respect for the dedication needed to remain focused. For example, it could have been too complex to do it justice. Awareness of this possibility drove the process forward. Rather than a burden, the depth was embraced, with the researcher focused on engaging with the text (Smith et al. 2009).

A hard copy was the best way to achieve a reading and initial noting in the margins. A range of important factors illuminated the lived experience of Amelia. Differences and similarities emerged within language and interpretation of the narrative. For example, the text was categorically split between childhood experience and adulthood experience. However, although there was an age demarcation, it was surprising how similar experience was in both. Additionally, initial noting is broken down into three discrete processes of exploratory commenting. These are descriptive (normal text), linguistic (italics) and conceptual (underline). An example of their use can be seen in Appendix (7a), where the reading corresponds with exploratory noting in the right-hand margin. At this stage Willig (2001: 55) suggests using psychological terms to illustrate observations.

Step 3: Developing Emergent Themes

Emergent themes were developed by unifying statements (Bradley et al. 2007). These included a range of themes and subthemes that fitted within both childhood and adulthood. Seven broad themes were initially identified. They had 'pithy working titles' of Context, Victimization, Health, Protective, Impact, Causes and Miscellaneous. For example, the theme victimisation appeared in both childhood and adulthood. In childhood the experience came from Parent, Siblings, Peer, and Institution (School). In adulthood, it came from Partner, Parent, Peer/Neighbour, and Institution (Outside Agencies). Victimization in this first case included abuse, bullying, rejection, and marginalisation.

An example of emergent themes identified in the transcript can be found in Appendix (7b). Initial noting is in the right-hand margin and emergent themes in the left margin. Although the notes and themes were basic researcher perceptions, they were based on initial interpretation of the participant narrative (Knight et al. 2003; Srivastava and Hopwood 2009). What was evident is that themes did not emerge in a linear trajectory but formed in pockets throughout the transcript. These pockets needed identifying and given consideration as to how they fit together. This requires a highly reflexive researcher to concentrate on the iterative process of establishing themes (Bruce 2007). It was encouraging that the text was engaging and insightful, but it was also complex. To counteract the complexity it became easier to colour-code text to create immediate visual identification of a theme, see Appendix (7c).

This aspect also entailed breaking up the transcript. Colour-coded text was copied and pasted to a corresponding theme file. For instance, the theme Context was green; Health was blue and so on. An example can be seen in Appendix (7d). No colour remains as that was unnecessary once extracted. This is similar to 'open-coding' (Strauss and Corbin 1990) or what Miles and Huberman (1994) refer to as 'tags'. The original whole becomes a set of parts as the hermeneutic analysis is conducted (Smith et al. 2009). However, the researcher must remain close to the lived experience of the participant to capture what is crucial but being influenced by the whole transcript (Bradley et al. 2007).

Step 4: Searching for Connections

In order to search for connections across themes, there has to be some form of mapping of how themes fit together. As with the other steps, the level of analysis is not prescriptive, the

analyst explores, discovers and organises what they see (Smith et al. 2009). Some emergent themes may be discarded at this stage if they do not fit with the research question. However, this is something more difficult for the novice researcher concerned with study integrity and promoting participant voice.

Emergent themes previously identified by colour-coding were explored. Appendix (7d) is an example, highlighting victimisation theme through the experience of parental child abuse. However, although these were very useful in managing the data in themes, they were still large data files. What became easier was to create a crude list to identify connections across themes (see Appendix 7e).

The range of higher and lower-level themes required information-management. In order to make sense of the vast data, a visual overview was produced. The most accessible way was to create a 'Mind Map' that harnessed the entirety of the information. An example of the first case can be seen in Appendix (7f). This shows a comprehensive overview of both childhood and adulthood. The participant Amelia (PPSF1) is central. From there, themes are colour-coded for ease of identification, moving from the whole (overarching theme) to the particular (participant extract). For example, Context is green, Reaction is blue and Impact is red. Other colours include purple to direct the eye to victimisation, abuse and trauma experienced. This visual representation acknowledges just how vast the story is without diminishing the intricate narrative.

Step 5: Moving to the Next Case

Mind maps were created for the next four transcripts to support data management for thematic overview. This was incredibly helpful to the continued process of analysis and for the ten remaining transcripts. Steps 1-4 were adhered to rigidly for the remaining fourteen transcripts. New themes, variations on themes and a general evolution of the process of constructing individual hierarchy of themes were achieved. The colour-coding system was used for each transcript, breaking up the text to copy and paste chunks of data to corresponding files. For instance, health = blue text. These were extracted from the transcript and placed in their health file. The health theme was then reconfigured to more specific subordinate themes of physical, mental, and emotional health.

Appendix (7g) provides a different case perspective to Amelia (PPSF1) on the initial noting and emergent themes identified. To move the analysis forward and improve the rigour, a superordinate table of themes was developed for each participant story (Yardley 2000). Two examples are provided in the appendices. One details the superordinate table for a participant who experienced child abuse (Appendix 7h). The second provides details of a participant who experienced childhood trauma (Appendix 7i). They are individual, separate, similar and different; but both followed a parallel trajectory in life. Their individuality is embraced here. In the next step, the analysis moves on to explore patterns across cases.

Step 6: Looking for Patterns across Cases

Across case analysis took place to determine patterns, similarity, or difference. Moving back from the part to the whole through re-examination was extremely helpful (Knight et al. 2003). This involved comparing the thematic structure of each participant against the sample whole. As convergences are not always evident (Smith and Osborn 2008) it was a case of seeing how content could fit together, rather than making it fit. Supervisory consultations assisted in providing clarity, balance and purpose to this process (Richards and Schwartz 2002). Creativity was necessary for being open to novel and unanticipated paths (Rapley 2011). Any material at odds with other cases can be put to one side (Smith et al. 1995). For example, one participant reported positive experience of the Police, whereas other participants reported negative experience. After revisiting transcripts to clarify understanding (Biggerstaff and Thompson 2008) this positive experience was recorded in the subordinate theme of Seeking Support.

Text from individual participant narratives was extracted to form a cross-case master table of themes. The process endorsed the participant voice in the table (part) and how their extract fits within the theme (whole). A number of examples are presented in the appendices. They include tables from both childhood and adulthood across the three master themes of Context, Reaction and Impact:

Appendix 7j: Childhood Context,
Appendix 7jj: Adulthood Context,
Appendix 7k: Childhood Reaction,
Appendix 7kk: Adulthood Reaction,
Appendix 7l: Childhood Impact,

Appendix 7II: Adulthood Impact.

Each table was explored to consider connections across-case. Themes were ordered through hierarchical coding similar to template analysis (King 2004). They included higher-order codes (superordinate) and lower-order codes (subordinate). This stage involved labelling, re-labelling and adapting themes to maintain the essence of the individual participant narrative and researcher interpretation. Subordinate themes were generated under corresponding superordinate theme. Most themes identified themselves as warranting a presence or not. Eventually, a cross-case identification of recurrent themes was developed into a table for each master theme. Examples are presented in Appendix (7m) for Context, Appendix (7n) for Reaction and Appendix (7o) for Impact. Recurrent was defined as being present in over half of the sample (Smith et al. 2009), thus adding to the validity of the findings (Yardley 2000).

At this stage of the analysis, themes evolved through a change of name more appropriate for final completion. This was most applicable for the master theme of Context. Superordinate themes were initially based on perpetrator for identification. However, as the focus developed themes based on the perpetrator were changed to a focus on traumatic experience. Theme structures were compiled for childhood (see Appendix 7p) and adulthood (see Appendix 7q). Following further analysis and amalgamation of some subordinate themes, a completed master hierarchy was settled on. The three master themes were populated with corresponding superordinate and subordinate themes to complete the process. An example of all three can be seen in Appendix (7r).

During the process of analysis, the study title and emphasis evolved. The term victimisation seemed limiting. The majority had experienced child abuse (such as psychological abuse) and the remaining experienced childhood loss of some kind (such as death of a parent). It became evident that having the right terminology to express participant experience was essential. Therefore, the study evolved the focus from victimisation to the more encapsulating term of childhood trauma (combining experience of the act/event, harm and lasting impact).

Unilateral Analysis of the Data

The data in this study was analysed by a sole data interpreter. This can create a researcher bias that impacts the process of data interpretation. For example, emerging themes may be

identified through a subjective expectancy. The researcher may see what they expect to see or want to see. It is preferable to have more than one researcher for inter-rater reliability. Data is interpreted independently and then compared in order to reach concordance of the findings. This did not occur in this study, but several measures were taken in an attempt to minimise researcher bias.

It is acknowledged that the process of qualitative data analysis is far more subjective than quantitative data analysis, since a definitive objective view of social reality does not exist (Burnard et al. 2008). As such, the analytic process is grounded in subjectivity, which can be embraced or minimized (Morrow 2005). Interpretivist researchers embrace the positioning of the researcher as co-constructor of meaning, integral to the interpretation of the data (Morrow 2005).

It is important to ensure reliability through meticulous records of interviews, observations and the process of analysis (Mays and Pope 1995). This audit trail allows observers the opportunity to trace the analysis step-by-step (Shenton 2004). In this study, the audit trail can be explored in appendix 6b through to appendix 7r. Overall, the quality of analysis is also determined by dependability (Patton 2002). That is, following a systematic process such as the IPA stages above. Morrow (2005) believes this renders the research transparent, regardless whether carried out by a conscientious lone researcher, a team, or by involving independent experts.

The addition of peer review (inter-rater reliability) seeks to guard against lone researcher bias (Burnard et al. 2008; Mays and Pope 1995) by establishing validity through the views of others (Creswell and Miller 2000). Data validation had been achieved during data collection (see Chapter 6). Returning to the sample for further validation was also considered, but dismissed in view of causing possible further trauma and harm (Goldblatt et al. 2011). Instead, the steps taken during analysis were considered by a number of qualitative and IPA assessors at various group meetings, master-classes and general qualitative support (Barbour 2001). In addition, key results were presented to mental health practitioners and service users at mental health and research events. It was also a core activity of supervision sessions.

On a final note, incorporating a reflexive approach through self-disclosure of personal values, assumptions, beliefs and biases aids transparency (see Chapter 9: Reflexive Practice). This is

supported by maintaining a self-reflective journal to examine decision-making, personal assumptions and goals (Barbour 2001; Ortlipp 2008). All measures were achieved in the current study and helped minimise the lone researcher bias of qualitative research.

IPA is subjective and as such, no two analysts working with the same data are likely to come up with replication of each analysis (Brocki and Wearden 2006). The data analysis is only one facet of the process, with analysis taking place from data collection and remaining throughout the study. As long as the analyst remains true to the principles of IPA, validity of the study is assessed in a similar way to other qualitative research.

Conclusion

The present study has provided several ways for the reader to assess validity. For example, extensive documentation provided in the appendices illustrates strength of analysis for improved transparency (Yardley 2000). In addition, an audit trail of methodological and analytic decisions has been highlighted throughout (Rice and Ezzy 2000a: 36). However, the test of real validity is whether the IPA researcher tells the reader something interesting, important or useful (Smith et al. 2009). Thorne (2000) suggests that qualitative research is credible if a critical reader can recognise how the findings provide a connection between actual data and conclusions reached and that these findings are believable. This can only be judged by the reader. The next chapter details ethical considerations for this study.

Chapter 8

Ethical Considerations

This chapter discusses the process of ethical consideration for the present study. There are several aspects to consider that form the basis of chapter structure. The first is Participant Wellbeing and reducing potential harm. The second is Researcher Wellbeing and reducing potential threats. The final section of the chapter details the Ethical Approval Process and the influence of legal frameworks, professional bodies and ethical boards.

Participant Well-Being

Ryen (2016) identifies three main aspects considered in Western research ethical guidelines. They include, Code and Consent; Confidentiality; and Trust. These will form the structure for considering participant wellbeing.

Codes and Consent

This essentially refers to 'informed consent'. The participant has the right to know that they are being researched, the right to be informed about the nature of the research and the right to withdraw at any time (Ryen 2016). Indeed, every effort was made throughout the whole research process to ensure there are no acts of deception (Colombo 2008). The participant should not be coerced, persuaded or induced in to research 'against their will' (Green and Thorogood 2009). It must be based on full understanding, capacity to consent and willingness to volunteer (Usher and Holmes 1997).

Obtaining informed consent was viewed as critical to the integrity of the study. As such, the research aims have always been overt and discussed openly. This commenced at all recruitment presentations and one-to-one discussions with each potential participant before they agreed to participate. To support this, a full written explanation of the research was given prior to the commencement of the interview (Appendix 5b) and then re-read at interview to ensure understanding. In addition, specific information about participant rights is detailed on

the consent form (Appendix 5c). Both participant and researcher signed this document as a contractual agreement for engagement in the research process.

Informed consent was also a concern at interview and ensuring the participant understood their rights and was comfortable to proceed. Therefore, as part of the introduction the participant was verbally informed of the voluntary nature of their involvement. At any point during the research study they have the right to withdraw. It was also reiterated that no adverse consequences will occur should they change their mind and wish to withdraw.

In view of the sample being drawn from a vulnerable population, the researcher considered the current mental health status of each participant with regards capacity to consent. People with mental health problems are presumed to be vulnerable research participants (Usher and Holmes 1997). Therefore, a judgement is needed as to their vulnerability. This was based on a three-way level of concern. For example, if any concerns were raised by the mental health charity staff, by the participant themselves or perception of the researcher at the time of interview. If necessary, the interview would be re-scheduled for a later date. However, Usher and Holmes (1997) believe it is the participant alone who has the right to confirm or deny consent based on their knowledge of the study and associated risks. For the present study no such concern transpired for any participant.

Confidentiality

Ensuring confidentiality is crucial for the ethical practice of any research. To achieve this, Colombo (2008) raises three important aspects required to safeguard participants identity, namely: the right to refuse, anonymity and confidentiality. This also includes the two colleagues who gratefully participated in a pre-test of the interview guide and interview process. Each will be addressed in turn:

Firstly, the right to refuse to answer any questions the participant feels may reveal sensitive information about them. This was discussed on arrival and also present on the consent form as one of the conditions of agreement. Although some questions may lead to anxiety and distress, this cannot be accurately predicted (Richards and Schwartz 2002). So questions that may cause distress can be refused or answered. Because the nature of this study is regarding childhood trauma, equal consideration was given to whether the participant wished to answer

or refuse. As there was no refusal to answer, attention was directed to managing sensitive information shared and participant reaction.

Secondly, assure anonymity through a system that assigns a code to individual participant information. All participants were ascribed a code as soon as they engaged in the process. Codes were devised as such: PPS = Participant, Number 1-20 = when they engaged in the study (5 engaged that did not confirm participation), F or M = gender. Therefore, PPS1F was the code for the first participant and used throughout the research process on all documentation (paper or e-copy). Because a code is impersonal when presenting the findings, each participant was additionally assigned a random pseudonym.

Finally, keep participant details confidential by storing direct contact information securely. Contact details of participants are only stored on one document. This has been retained in a locked cupboard, within a locked office in accordance with the Data Protection Act (1998), see Appendix (8a). Personal details were also kept separate from the study information in electronic form on a secure server.

Another consideration is the venue where interviews will be conducted. Because all participants were recruited from mental health charities, all but two preferred to be interviewed on charity premises. The venue is familiar to the participant as an everyday environment (Orb et al. 2001) and this added security. They agreed to being seen there and in fact, had informed staff and were in agreement that staff be available if necessary. The rooms allocated were always appropriate interview rooms away from main activities, to maximise confidentiality.

Trust

The issue of trust refers to the relationship between the participant and the researcher and researcher responsibility not to 'spoil the field' for others (Ryen 2016). It also applies throughout the process and in particular, ensuring the voice of the individual is present in analysis and the final report (Smith et al. 2009). Indeed, describing their experience in the most faithful way is the most critical ethical obligation of the qualitative researcher (Munhall 1988).

With the subject matter of poor physical and mental health, victimisation, and trauma and so on, strategies were needed to minimise distress. For instance, during the interview it was imperative the participant was able to feel comfortable, express their story and their agenda and not be fixed by a forced research agenda. Should the interview become distressing, it would be stopped and reconvened after a break or at a later date. In addition, provision was made for assistance from charity staff should this be needed. Also, the contact details of a number of confidential organisations, clinical services and self-help groups were listed on the Interview Completion Sheet (Appendix 5d).

Another major concern was regarding a participant disclosing potential or actual risk of harm or crime. Preparation was necessary before commencing the study. Therefore, concerns were discussed at each recruitment presentation and added to the Participant Information Sheet (Appendix 5b). This was to reassure participants that information would remain confidential, unless a moral or legal obligation forced the issue. No action would be taken without the full consent and support of the participant. Firstly a discussion would establish the nature of the risk to consider if the information needed acting on. If so, this may entail involving the police with support from the mental health charity. This would be a difficult judgement call (Green and Thorogood 2009: 71). Fortunately no issues of risk surfaced in any of the interviews.

The majority of participants stated that the research experience was a positive one. Many expressed their gratitude in being listened to. It also appeared to provide a period of reflection for them. The subject of victimisation, abuse and trauma are rarely discussed, even in clinical services. A number also felt comfort that their story may help others and improve services, once published. It is believed that this level of appreciation and positive contribution was achieved by treating participants as individuals and respecting them as people and not objects of research (Colombo 2008).

Researcher Well-Being

Potential issues that could have arisen to compromise researcher wellbeing were identified during ethical approval, annual review and research supervision. For example, researchers need to acknowledge ethical issues when they arise. Also, be aware of their own feelings regarding potential sensitive disclosure and how to deal with this accordingly (Wagstaff et al.

2014). One major aspect for improving ethical practice is having access to someone to talk through ethical dilemmas. They may be a supervisor, colleague or even an internet forum (Miller 2012). All of which were accessed during this research study.

Craig et al. (2000) suggest thinking about potential threats such as physical threats or abuse; psychological trauma; potential for compromising situations; and increased exposure to risk of infection, disease or accidental injury. To minimise risk, an assessment is necessary before commencing the research. In the present study informal consideration of risk was conducted. Mental health environments, the vulnerable population, fluctuations with situation such as crisis are all familiar to the researcher. With the support of supervision, discussions with charity staff and interviewing in safe, staffed, charity accommodation reduced potential risk.

If there was any sense of hostility from the participant then the interview would be postponed rescheduled or cancelled. Psychologically there was a definite threat of vicarious impact. The information shared was traumatic and brutal at times, in the knowledge that discussions centred on the participant as a child. Sometimes this was thought-provoking and other times it was emotionally upsetting. Attempts for detachment could be breached as a result of empathic and compassionate response. This was conveyed in a number of interviews but mainly contained and processed afterwards. Most often this was dealt with individually. When necessary, research supervision provided an additional outlet. Such support is beneficial but often lacking in UK institutions for qualitative researchers (Bloor et al. 2007).

Potential for compromising situations was also a risk that needed minimising. The population are vulnerable and this raises concern for their safety and that of the researcher. Communications can easily become misunderstood or misread. It was essential that all communication was reiterated and confirmed. Study documentation supplemented verbal engagement. Boundaries were ensured during the whole research process, but in particular, the interview (Richards and Schwartz 2002). This included study-focused discussion, starting the interview on time, maintaining a respectful interaction without inferring friendship, completing and sharing expectation for any further involvement (withdrawal, summary of results). There were no concerns for exposure to infection, disease or injury.

Ethical Approval Process

Good ethical practice involves awareness of participant and researcher wellbeing and preparation to minimise risk throughout the research process. In order to achieve this, approval is required from various organisations and adherence to professional bodies. For example, Green and Thorogood (2009) provide four aspects that require ethical consideration in research:

1. Legal Frameworks

This includes national law (confidentiality, consent/disclosure, criminal law, civil law). This has been dealt with above regarding disclosure of risk or crime and also storing confidential information in accordance with research principles and data protection act (1998).

2. Disciplinary codes of practice

There are three codes for consideration and adherence to here, as a nurse, an employee and a researcher. The first is the Code for Nurses and Midwives (NMC 2015). As a nurse the researcher adheres to the code to uphold the reputation of the profession and promote public confidence in nursing. An example of the more poignant sections is presented in Appendix (8b). The second is adherence to Coventry University Code of Conduct for Employee Behaviour (2010). As a lecturer, this code ensures the standing of the university is maintained by all employees in whatever work is conducted in their name. Thirdly, Principles and Standards of Conduct on the Governance of Applied Research (2009) make certain the researcher conducts research within strict university research guidelines to minimise harm.

3. Local cultural norms of ethical conduct.

Where the research is being conducted is significant. Consideration of local norms is necessary when 'entering the field'. All four mental health charities had individual ways of working and particular focus. Some were more political than others, some focused more on social events than others. Understanding this was useful and also seeking advice and assistance from the regional manager of each proved insightful for expectation.

4. Formal Ethical Review; Ethics Committee

Ethical review of proposed research is a formal process requiring approval from an ethics committee before commencement. For the present study, application for ethical approval was sought from Coventry University, through the Registry Research Unit. A complete research proposal was submitted along with an ethical approval form. Following review by the ethics committee, approval was granted on 6th December 2011 (see Appendix 8c). There were minor conditions applied to the actual research proposal that required updating with regards to method. This was rectified.

Although the four mental health charities accepted the university approval, two had further conditions. The first was MIND who required the research study information to clarify what constituted police involvement and if participation impacts on psychiatric treatment. This was adapted with their support and clarified for potential participants. All correspondence was conducted face-to-face and so no documentary evidence exists.

The second was Rethink Mental Illness who required the completion of a 'Recruitment to Research' form. This was duly completed and accepted by the charity via email. Unfortunately the email correspondence no longer exists. The addition of 'AIMHS' (Actively Improving Mental Health Services) and 'Making Space' were also contacted. Following a meeting with the regional manager of each charity both agreed to being approached for participants. They required no further ethical approval as the study had already met ethical requirements for Coventry University, MIND and Rethink Mental Illness.

Conclusion

Ethical practice is fundamental in maintaining the integrity of the research as a whole (May 2011). Preparation to protect against potential harm is essential to participant and researcher well-being. This was achieved through layers of pro-active consideration at each stage of the research process. It starts with the research question, through to faithful representation in the final report. As the participant is central in this study, their welfare is paramount. Attempts to safeguard have been employed throughout and identified in this chapter. The next chapter looks at how reflexivity enhances ethical practice through exploration of interactions between the researcher, the research and the researched.

Chapter 9

Reflexive Practice

This chapter focuses on the process of reflexive practice applied here. The format will be different to the rest of the thesis, with reflexivity requiring a first-person approach (Berger 2015). The purpose is to turn attention inward on the researcher and their intellectual and cultural traditions (Alvesson and Skoldberg 2009). This involves reflecting back on thinking throughout the study (Shaw 2010) and what Finlay (2000) terms, 'outing' the researcher. Reflexivity refers to the active acknowledgement that the researcher is an integral part of the world being studied and will inevitably impact on the meaning and context of the experience (Horsburgh 2003). In addition, it enhances ethical practice in the field, where research ethics committees are not accessible (Guillemin and Gillam 2004).

The chapter will be structured around the five types of reflexivity identified by Finlay (2002). These are, namely: 1. Introspection, giving insight into the researcher and how I came to be involved in such a process; 2. Intersubjective reflection that considers the mutual meanings emerging from the research findings; 3. A brief exploration of mutual collaboration; 4. A social critique to explore power dynamics; and 5. Discursive deconstruction.

Introspection

Personal introspection is useful in exploring the researcher's own experience and personal meanings (Finlay 2002). To commence I will detail my background history and any factors of influence. For instance, I am a white British male aged 48 years old. During the period of conducting of the interviews I was 44 years old. My upbringing was somewhat modest. I grew up in a south Birmingham suburb of social housing within the vicinity of three mental health hospitals. The grounds were open and as children we were able to walk through and explore. I remember even then, having no fear of people with mental illness. Rather, I felt empathy for their situation.

Throughout my childhood and even today, two main features dominated my life, sport and music. I enjoy the juxtaposition of the necessary discipline, alongside the creative expression. At school I was quite studious until teenage years when I lost motivation. As a result of insufficient revision, I left school with minimal qualifications. However, I was able to redeem myself when I passed the nursing entrance test and was accepted for nurse training at one of the local mental health hospitals. I commenced my 'nurse training' and found a role I could excel and enjoy. I remained at the hospital for the three years training and then two years working on a rehabilitation ward. I really enjoyed my time there, but needed to move on. The hospital was closing and facilities were being set up in the community.

My heart was set on working in the community, but not in a home, a unit or a small hospital. I wanted to work in a more autonomous role. I achieved this as the first community staff nurse in the locality. All other community staff at the time was of a higher 'rank'. I remained there for eight years and attained several additional qualifications, one of which was my Masters Degree in Counselling and Psychotherapy. Whilst working in the community I was able to work on a one-to-one basis with a range of people from a variety of socio-economic backgrounds. This enabled me to improve and develop my skills and gain insight into the lives of people with mental health problems.

With regards to childhood abuse and trauma, there were a number of people I came across during my career that I felt helped me understand; in a way that the mental health system did not. One experience of note was working with a young woman aged 22 years old who had become isolated at university some 150 miles from home. She began to exhibit thought disorder and symptoms of psychosis. Asking what happened to her she explained that her brother had sexually abused her in early adolescence, culminating in rape. Having time alone at university allowed for memories to re-surface and impact on her ability to function, self-identity and actual survival. She was suicidal and had to return to the family home where memories intensified. Parents were unaware as she did not feel able to inform them. This remained with me throughout my career.

My philosophy is to treat people as equals and always attempt to accommodate. I have never felt a sense of 'them and us' within any position I have held as a nurse. So I was interested when, during the 1990s, the perception of mental illness was changing. For instance, service

users talked at conferences and produced books of powerful importance. It is at this time I became interested in anti-psychiatry, but probably favoured a more critical or post-psychiatry understanding. Writers such as R.D. Laing and Thomas Szasz exposed what I thought was obvious but was plainly ignored or misunderstood, because changing the system was a step too far. However, it wasn't until I read the modern text: *Models of Madness* (Read et al. 2004), that I was encouraged to produce my own edited text with a colleague on critical issues in mental health in 2008.

Intersubjective reflection

This section focuses on the situated and negotiated nature of the research encounter (Finlay 2002). It is about considering how the findings are co-constructed through shared meaning. As a qualitative researcher, the purpose is to explore the context in which I come into contact with objects and the way in which my descriptions of them are bound by time and place (Shaw 2010). Phenomenology can help me achieve this within the specific research design of IPA. The appeal was instant and I believed in the process being favourable with participants. I could focus on finding out what had happened to them, how it impacts their life, how I can make sense beyond description and how I can ensure they are central. This was absolutely achievable through Smith et al. (2009) IPA. It is flexible and reflexive without being prescriptive; an important factor for phenomenology (Finlay 2014).

In the process of the research I was both subject and object. I was reflected in the participants and they were reflected in me (Finlay 2008: 106). This was evident in a shared background, a shared understanding and a mutual respect. One aspect of awareness was my previous role as nurse and therapist. For me, I focused on being present as researcher. As Gadamer (1975) suggests, it is important that when two people meet, if the two horizons overlap we can be mutually understood. However, the role of therapist did occur on occasion. For example, when discussing mental health problems, some participant became comfortable in sharing information as if in assessment or clinical update. Awareness enabled me to hear them but readjust the interview to focus on understanding the participant, as well as their psychiatric self.

Mutual meaning making starts with the initial introduction. I spoke to many groups about the research. An opinion of me is first formed then, as well as my initial thoughts of them.

Interpretation of the research question, whether someone could work with me, whether I was understood, whether they were understood, all came to fruition in the first moment. Meaning making commences here with the new relationship born. During interviews, I was conscious for the participant to feel some control of the process. Many looked to me as the obvious lead, but this was not the point. For me, the point is not who leads, but whether enough autonomy is present. To ensure the participant experiences a control over what to add, what to leave, what to answer, what not to answer. I believe this was successful and demonstrated an ethical and reflexive approach.

Having worked in mental health care and teaching for my career, I felt comfortable with all participants. At no point did I feel threatened or intimidated, concerned or unsure. Instead, I felt emotion and connection; privilege and surety. I was convinced we were achieving something meaningful. What I was not aware of was the content to be shared. For example, my first assumption was that the focus would be on hate crime, peer victimisation and neighbourhood ridicule. Peer victimisation was evident across the sample, but there was no hate crime reported and limited engagement with neighbourhoods. Although this was quickly established it meant that I had to establish mutual meaning. This encouraged me to be more focused on what was actually shared and I believe, improved the interviews.

Once the meaning was analysed and interpreted, it is necessary to increase awareness of maintaining the essence of what was said. Alvesson and Skoldberg (2009) believe the utmost awareness of theoretical assumptions, importance of language and pre-understanding; all constitute major determinants of the interpretation. I was conscious not to force any theory onto the emerging narrative but to personally interpret what I saw as a story behind a story, my double hermeneutic. Although I use psychological literature to articulate the interpretation within the discussion, it is still my interpretation of the narrative and provides the shared meaning.

Mutual collaboration

Research participants also have the capacity to be reflexive beings who can be co-opted into the research as co-researchers (Finlay 2002). However, this was inappropriate for this study for two main reasons. The first is the sensitive nature of the subject matter. Being co-opted into the research and reflexive process could place the participant at potential risk of harm. This was avoided for the same reason member checking was avoided. Vulnerability to reviewing their words and the powerful impact of what had been said was a concern. In addition, engaging in reflexivity following a prolonged interview (approx' 90 minutes) to discuss the research process seemed excessive. The second reason is based on the use of IPA as the research design. With a focus on the double hermeneutic of the relationship, reflexivity that incorporates participants as co-researchers will alter the dynamic of the relationship with the data in analysis.

Other forms of mutual collaboration include a team approach to research, seeking group understanding and the inclusion of multiple voices. A team approach was not applied here, however, in an attempt to improve understanding of my findings I received regular supervision, often engaged with a local qualitative research community and had contact with an IPA email based group. Although not directly and obviously a part of the research, they definitely formed a collaborative input to help me move beyond preconceived theories and subjective biases (Finlay 2002).

Social Critique

A concern for researchers using reflexivity is how to manage the power imbalance between researcher and participant (Finlay 2002). Indeed, concerns regarding the negative impact of power in researcher and researched relationships can be addressed through reflexivity itself. For example, its use in situating the researcher as non-exploitative and compassionate toward the research subjects (Pillow 2003). However, Finlay (2002) also advocates caution with regards to deconstructing researcher authority. She suggests that preoccupations with egalitarianism can divert attention away from more pertinent issues and even create more authority.

The issue of authority was present for me from the beginning. I was conscious that my position could be viewed as authoritarian and attempted to minimise this. I did not want my social confidence to be misconstrued, so adjusted my conversation and presentation accordingly. The first point at which any direct power-dynamic is truly evident is the interview. I was present in the role of researcher and hoped that would reduce any status I may have been afforded. It was important that I did not hold a superior position. For me, I was gratefully present with each participant; privileged to have access to their private past, pain and sorrow (Sullivan 1998: 74).

I was comfortable with each participant and had no issues with what they said or how they said it. On occasion I believe I was tested. Some aspects of abuse were crudely portrayed, some aspects of trauma, emotionally charged. There may have been tests to check for my reaction to such powerful accounts or indeed, just feeling comfortable to share. Reading over the narratives, I would suggest it was both. Some of the topics discussed had never previously been divulged or certainly not explored. I felt free to encourage rather than question. This proved fruitful but also raised my awareness that they were sharing sensitive aspects of their lives. I found silence proved the best gauge. If this prompted an end to a topic then I would honour that. It was not my place to pursue.

The responsibility for each personal account has been a driving force since the interview (Dickson-Swift 2007). For example, conducting the analysis, write-up and presenting the findings have all been with the participant voice present and central. Reflexivity has been helpful as an awareness of ethical moments (Guillemin and Gillam 2004) and constant reminder to remain true to the intention of the research. Throughout the research journals are observations, deliberations, concerns and insights that increase awareness of assumptions and biases (Morrow 2005). A powerful example for me was when I realised mental health problems played a minor role in participant life but formed a major part of their identity. One of my extract reads:

The impact of mental health problems is one of many impacts, but for the majority of the participants, if not all, it becomes the largest part of their 'identity', coping strategy, occupational and recreational time, focus!! [19/10/2014]

I felt very careful to consider my position and whether I was imposing a view or reflecting a view. I believe it is the latter.

Discursive deconstruction

In reflexivity as discursive deconstruction, attention is paid to the ambiguity of meanings in language used and how this impacts on modes of presentation (Finlay 2002). This is a challenge but one that can be overcome. In the interview I attempted to do this by checking meaning. For example, some participants had poor verbal communication and others had strong geographical accents and sayings. I would clarify immediately, or write in my journal and return to the topic later. I was aware not to keep clarifying and checking. It stopped the flow and could be annoying. Anything missed was picked up during transcription and analysis.

Each person perceives the same phenomenon in a different way, each bringing to bear their own lived experience, understanding and history (Heidigger 1953/2010). In conducting a phenomenological study I reconciled with this early on. Whilst not all meaning and understanding can be captured, a majority is. Conversely, it should not always be left to words to convey meaning. Language is important, but how it is conveyed has equal importance. For example, meaning was also elicited through emotion and non-verbal communication recorded in the research journal. The words that answer a question are all the more important when understood within the context. Stated in a dismissive way, stated through tears, and stated with disdain all provide meaningful perspective.

Ambiguity in the meaning of language requires careful decision-making with regards to theme placement and presentation. In IPA the narrative must provide context. For me, it was not acceptable to trim an extract or provide a pithy core. The narrative must speak. I believe this allows for a more genuine understanding to be conveyed. There is also a duty to go beyond the words to understand the psychological and cultural significance of the words (Mauther and Doucet 2003). I feel I was fully aware of the political context of the environment, the lifetime of experience amongst the participants and their socio-economic status.

Conclusion

The need for reflexive practice during the research process for social science is very valuable. Of interest is the process of sharing aspects and the history of one's self. This provides some insight, context and intention, with regards to the research. My framework of understanding is shared here, with necessary awareness and adjustments conveyed. I believe these are the sorts of factors that influence my construction of knowledge and are revealed in the planning, conduct, and writing up of the research (Guillemin and Gillam 2004).

This chapter has shared the process of how I got here. It has determined why I chose what I did and also the way in which to explore. The next stage of the thesis is Part Three: Findings and Discussion. This will provide the narrative; the interpretation and the conclusions made that really hold the emphasis as to why I did this and why I did it this way.

PART THREE

FINDINGS AND DISCUSSION

Part three presents the findings and discussion of the study. Three chapters provide analysis of the master and super-ordinate themes that emerged from the findings and a fourth chapter presents a discursive interpretation of these themes. Each master theme represents a progressive understanding of the relationship between childhood trauma and mental health problems. Within each master theme, a number of superordinate themes detail the lived experience of the participants. Participant extracts presented in each chapter were selected on the basis of representing the essence of the theme. Of note is that experiential responses relating to one of the four research questions on the '*causes of childhood trauma*' were very sporadic. In general, findings on this issue were not a prominent feature of their lived experiences and so represented occasional attempts by some participants to try and make sense of the abuse they suffered. These issues are discussed in Chapter 11 under the subordinate theme of 'Sense making'.

The first chapter is: *The Nature of Traumatic Experience*, detailing the range of trauma suffered during childhood and into adulthood, including abuse and loss. The chapter is organised around three superordinate themes, which include: *Maltreatment, Disbelief of Rejection* and *Powerlessness within Family Life*. The second chapter is: *Coping and Adaptation to Childhood Trauma*, providing insight into the way participants attempt to cope and adapt to their lived experience of trauma. Three superordinate themes emerged, including *Protection, Repressive Coping* and *Retaliation*. The third chapter is: *The Impact of Childhood Trauma*, providing a comprehensive overview of the pervasive and profound way trauma impacts their lives. Three superordinate themes emerged, including *Distorted Perception, Segregation* and *Poverty of Well Being*. The final chapter is *Discussion*, which discusses the findings against research evidence and extant literature for *Social Attachments, Additional Theoretical Frameworks, A New Psychosocial Model*, and *Policy Implications*.

Participant Acknowledgement

A phenomenological study requires individuals willing to engage in the interview and commit to their private and sensitive information being included. Although the process is confidential, the integrity of this study owes a debt of gratitude to the people who gave their story so freely and without restriction. In-keeping with the ideographic nature of IPA, each participant is introduced individually in the form of a pen portrait in Appendix (5e). Each portrait provides a brief introduction of the participant, brief observations from the interview and an excerpt from their transcript that is representative of them.

Chapter 10

The Nature of Traumatic Experience

This chapter critically interprets the findings organised around the first master theme to emerge from the analysis, namely: **The Nature of Traumatic Experience**. This theme helps understand the range and forms of trauma participants suffered during their childhood and the continuation of traumatising experiences into adulthood.

The chapter will be organised around three superordinate themes defining the **Nature of Traumatic Experience**, which include: *Maltreatment*, *Disbelief of Rejection* and *Powerlessness within Family Life*. Table 10.1 presents the cross-case identification of themes. This includes superordinate themes and their subordinate themes, with the addition of further sub-categories where necessary. The participants experience is easily identified as occurring in childhood, adulthood or both within this visual overview.

Table 10.1: Cross-Case Identification of Recurrent Themes: The Nature of Traumatic Experience

Themes			Participants															Present in over half of the sample	
Master Theme	Superordinate Theme	Subordinate Themes	I	J	A	A	P	O	S	W	J	N	E	E	S	I	F		
			s	a	m	v	o	s	o	p	a	m	a	v	e	s	a	r	
			l	c	e		p	c	p	l	i	h	i	l	c	a	b		
			a	o	i	a	y	r	h	i	s	e	e	a	r	e	d		
The Nature of Traumatic Experience	Maltreatment	Abuse: <i>Sexual</i>			X	v	v	O	X						v			No	
		<i>Physical</i>		O	X	X		v	X	X	X	X	O	X	v	O	v	Yes	
		<i>Emotional</i>	X	O	X	X	X	X	X	X	O	O	O		v	X	v	Yes	
		<i>Witness</i>							v	v		v		v			v	No	
		<i>Financial</i>	O		O			O	O	O		O	O				O	O	Yes
		Neglect	O	v	X	X	v	X	X	v	O	v			O	O	O		Yes
	The Disbelief of Rejection	Disregarded	O	X	X	X	X	v	X	O	v	X	X	X	v	X	X	Yes	
		Loss: <i>Absence</i>		v		X	X		X						v	O	v	No	
		<i>Death</i>	v	v			O					O			v			No	
		Stigma			O	O			O	O	O		O	O			O	Yes	
	Powerlessness of Family Life	Restricted by Control	v	v	v	X	X	X	X	X	O	O	O	X		v	X	Yes	
		Familial Influence					X	v	v	v	X	v	v	v	v		X	Yes	

Key:
v = Childhood,
O = Adulthood,
X = Both child and adulthood

Superordinate Theme 1: Maltreatment

The superordinate theme of Maltreatment is interpreted in terms of two key subordinate themes, namely: **Abuse** and **Neglect**. They refer to any action by another person that causes significant harm to a child (NSPCC 2016) or an adult (SCIE 2013). The majority of participants experienced such maltreatment.

Abuse: ‘There was no just ending’

The experience of child abuse was prevalent across the sample, with the majority of participants recounting at least one serious incident of sexual, physical or emotional trauma. As can be seen in Table (10.1), many experienced a range of abuse across the lifecourse. Each abuse has been presented as a specific subtheme due to the depth of the data collected and

need to provide a distinction for each experience of abuse. No significance is implied to the order themes are presented.

Sexual Abuse: 'I let them abuse my body': The childhood experience of sexual abuse was described by a number of participants, recounting intra-familial abusers. They all shared a context that the sexual abuse was a continuous experience, occurring frequently over a number of years from one or more abusers. Although the accounts are powerful, the child sexual abuse is often mentioned in a seemingly matter-of-fact way. For example, Ava mentions abuse by her father.

'Errrm, and errrm, so there was that... Errm, and then I was abused by my Dad and so, I think that's why I ended up being very errm, together... do you know what I mean... On my own... and stuff... and not needing anyone...' [Ava: P:12. L1].

The start point is often early childhood and continues consistently into teenage years.

'(Int: And how old were you, when your Dad abused you?) Errrm, I moved a fair bit... and it must have been when I was about 7 or... 8. Yeah (quiet)... (Int: For how long? (quietly))... (difficulty getting her words out initially)... for a few years... on and off. Errrm, you know... errm. Yeah.... (pause)... There was no just ending really...to me there was just like... Huh!' [Ava: P:12. L:15].

Others mention sexual abuse from a range of family members without initial identification. In this extract, Ella describes a range of abuse experienced and later establishes the inclusion of parents and grandparents.

'...a lot of the memories that have come back... have been abuse of abuse from all the adult members of my family... (Int: Mmm) Both physical and sexual... and ritual abuse... and... quite a lot of emotional abuse...' [Ella: P:19. L:35].

'In terms of the abuse...I had parents who were abusive...who had been abused themselves... both sets of grandparents abused me... (Int: Mmm) So... I was born into a family... that was very... steeped in abuse and it was still going on...' [Ella: P:32. L:19].

Siblings also featured in the accounts of participants. Amelia describes child sexual abuse perpetrated by her brother.

'So somewhere between, six, seven, eight... that sort of age... is when it started... and it started with my brother... He left school... And wasn't working at the time... and Mum had left... (pause), Mum had left me at home with him, 'cause I was off school...' [Amelia: P26. L:3].

She goes on to state how the abuse extended to include others.

'...shortly after... you know... my other brother got involved... and then... a friend of his... sexually abusing myself and my sister...' [Amelia: P26. L:12].

In another account, Poppy discusses her two brothers attempting to sexually assault her. There are two aspects of significance here. The first is the younger age of her brothers and the second is that this is the only account that details consequence.

'My two brothers... one is six years younger than me and the other one is seven years younger than me... They got put into foster care... when they were about phееееeww... about eleven/twelve years old. (Int: Mmm) Because what had happened... my Mum was down stairs cooking and like... me and my sister got our bedroom and my sister was out... My two brothers had their bedroom and they... they called me in and I thought they wanted to have a look at something... and they'd actually tried to RAPE me... when I was like a young teenager... You know... it was only the once... that they did it... but the once was enough...' [Poppy: P:16. L:11].

Opportunity and environment play a major role in each participant account. This is reiterated by Sophia in an account of child sexual abuse whilst an adolescent in-patient being treated for mental health problems.

'... one of the trainee student nurses ... he started having sex with me... you know and all that... pressured me into having sex with him... and although they were asking me questions about it... I didn't feel I could talk about it...' [Sophia: P:4. L:1].

Later in the interview Sophia describes her experience at school. Here, there is a distinct difference in her tone and perception.

'Well... at Junior school it was the boys chasing after me... and... To try and have a sexual experience off me...' [Sophia: P:43. L:16].

Sophia continues the account in more detail. Although an awful experience, she illustrates an ability to fight back when faced with peers.

'...then the boys... that was when I was leaving school... they'd be waiting...to get me... you know like...waiting for a route, you know, to get me when I came out of school... and I'd try to go to different routes but they'd always be waiting... so I'd try to run away from them and stuff... and... it was hard, you know... sometimes they'd get me and sometimes they wouldn't... (Int: And what would happen?) Well they'd try to get your clothes off and that... and you'd be fighting with them to get away... it was really horrendous... You know...' [Sophia: P:44. L:21].

In adulthood the experience of sexual abuse continues for some. Although participants described events as more discrete than continuous, they were extremely significant. For example, Amelia provides context to her current relationship status before highlighting a serious sexual assault.

'I mean, as far as the kind of like, sexual abuse impacting... it does, even today it does...errm, and I think, you know I mean, I've made an active choice... to remain single... That's why I wear a silver ring... to kind of like... fix my brick wall, barb wire whatever you want to call it... (Int: Mmm) Errm, 'cause I don't want to be in that place where there's a potential relationship... because I've been on my own for seventeen years and I don't want to go back to... (Int: Mmm) Because every relationship I have had... has been incredibly negative... I think that's because of my... responses...and reactions due to the level of abuse as a child... (Int: Mmm) Because I haven't had a relationship that's lasted... My relationship with my husband lasted the longest... and we were together a couple of years... but even then... after we married... err, he raped me... So...you know, like... history repeats...' [Amelia: P:43. L:6].

Oscar gives an account of his experience at the hands of peers in adulthood. During the interview he appeared tormented by these events.

'...most of them touched my penis... men have...I said I didn't want to let 'em... I didn't want to let 'em... but I shouldn't have let them in the first place... I let them abuse my body... I let them take advantage of me...' [Oscar: P:5. L:13].

Physical Abuse: 'She tried to strangle me': Physical abuse was described by the majority of participants in childhood. Incidents are recounted across a range of assaults, from a number of people in their life. They all discuss the ongoing nature of the abuse through the presence of a constant threat. Accounts of physical abuse in the family involve either a parent or a sibling. Incidents involving family are the most graphic and most brutal in description. This is illustrated by Sophia describing her mother using a chain to strangle her.

'She (Mother) tried to strangle me once... I think it was when I was really depressed and she was really fed up... you know, exasperated and she was just testing out what my reaction was...and she put this chain or something... I don't know if it was a chain or something around my neck, to try to strangle me... I think she wanted to see if I'd fight for my life or something...you know... really weird...' [Sophia: P:40. L:27].

Other acts of violence were equally disturbing. Here, Oscar shares a powerful image of an assault at the hands of his mother.

'...my Mum got poorly...and used to play up herself and mop all shit all over the house... estrem... extrem...what's the word...excrement... what's another word for shit? (Int: Excrement...?) Excrement... that's it... and rubbed it all over my face and all over my clothes...' [Oscar: P:6. L:30].

There was also discussion regarding punishment with some participants describing heavy-handed physical punishment being metered out by parents. Amelia describes her experience with both parents.

'It was the strap (punishment)... ha ha ha (laugh out loud)... Errm, you know... basically we got beat you know... errrm, mainly at night... you know... If we were sent up to bed and we were talking... it would like... depending on who it was...you know, whether it was Mum or Dad... err, we'd get slapped and Dad would use the strap and Mum would use the slipper... errrm, and there was a lot of shouting... you know... a lot of sort of verbal sort of, 'I'm going to kill you if you don't...' (said with anger and through a low voice). You know... that sort of stuff... All the time...' [Amelia: P:31. L:10].

William gives a vivid account of punishment from his father.

'Well... If we did anything wrong, he (father) would hit us... and he'd go mad at us and we'd have to hold the door while he was breaking it down. He split many a door... Once he got through and I opened the bedroom window and 'cause I was one up I was just about to hang and drop and he grabbed me by the hair, pulled me in and hit me... and another time... errr... errrr... errrm, he got the back of the washing machine, you know, the rubber hose what pumps the water out... he hit me with that and I'm not joking...I never moved so fast... That, that was worse than the cane... I had the cane twice at school... it was ten times worse than that...' [William: P:28. L:11].

When discussing incidents of violence in the family some would attempt to soften or lessen the impact of the narrative. For example, William recalls the level of violence reached with his brother, but with a level of humour in his tone.

'...he (Brother) broke this pencil in me... stuck a pencil in me as hard as he could and it broke in me, the lead... ' [William: P:33. L:24].

Others such as Sophia reflected on their experience of sibling violence through a more frank, straightforward outlook.

'Well he's just really... bombastic... like, horrible, you know...I remember that if you were watching anything on the TV, he'd just come in a turn it over...and then if you turned it back... he'd start hitting you... you know... Errm, he was kind of disturbed in a way... ' [Sophia: P:37. L:16].

Outside the home, many participants experienced a continuous threat of violence in or around school. They described being bullied, hit, pushed and attacked on a daily basis. Here, Amelia offers some insight.

'...Most of the time... I tended to... I mean, you know, I was poked and my hair was pulled and... you know, things like that... ' [Amelia: P:33. L:35].

Several had similar experiences at school. Here, Noah shares his.

'I was bullied... (Int: You were bullied?) Yes, in the playground... (Int: By who?) By the school kids... (Int: Why did they bully you?) I don't know... (Int: What did they bully you about?) I don't know... They try and hit you... set about you... ' [Noah: P:23. L:27].

The bullying tended to be constant within the classroom and playground. However, often specific incidents stood out, as described by Scarlett.

'Errrm, in year seven I was, no it was year eight, I was pushed down the stairs at school and... it was an entire flight of stairs...and... I fell onto the bottom of the stairs and I chipped my knee and... that still hurts now... (Int: Mmm) ...especially when it's cold or when I swim too much... Errm, in year nine, I was chased down a corridor and beat up in a toilet... cubicle... Errm, I went on a Ski trip in year ten and... I was tripped over when I was skiing or pushed, so I flew into trees and stuff... ' [Scarlett: P:15. L:34].

The presence of physical abuse at school was not limited to the children. A number of participants mentioned being punished by teachers. The following extracts illustrate the violent methods used.

'I used to get the cane at my school... it used to be a special school... (Int: Mmm) They moved from (...) to (...)... (Int: Mmm) Up (...) Lane... and used to get the slipper off the headmaster...' [Noah: P:20. L:25].

Some believe such punishment is taken too far.

'So you got caned... (Teacher Name Redacted) you know, had me in tears. Well I was in tears... That to me is taking things to extreme... I am sorry to say... but I just think it is...' [James: P19. L:4].

Amelia provides a vivid account of violence she experienced at the hands of the head teacher.

'My Mum had given me some biscuits for break time... and I hadn't got a pocket so I tucked them into my sock... I hadn't got a pocket, I hadn't got a bag... so... and I remember the head teacher... I mean it wouldn't be allowed now... she took the biscuits off me and I remember her giving me an absolute leathering (smacking) with her hand... slapping me really, really... several times... And I have no idea to this day, why..?' [Amelia: P:32. L:4].

There is evidence from the participants that the adult experience of physical abuse is a continuation from childhood. Similar incidents are described, with the majority of participants highlighting at least one serious incident; others experiencing several. The level of familial violence portrayed is high, with partners replacing parents. For instance, female participants who had been married recalled physical suffering at the hands of their partners. Evie recounts a harrowing memory of being strangled by her husband. This was one incident recalled by Evie among many. The emotional context is apparent, as she retrieves the memory.

'...and I think... I remember one instance when I know he'd got... He'd got... tut... he'd (Husband) got a rope round my neck (said with emotion, breaking voice)... and he was pulling it really tight...' [Evie: P:33. L:19].

In addition, participants described how they became used to the experience of violence from their partners.

'Yeah I was hurt...I think... at the beginning he was more physical... would throw things or... you know? Huh... we did have an argument when he tried to strangle me... ha... errm, ha ha (nervous laugh)... And errm, huh... and I sort of took the... you know... took the apology... so... yeah... Yeah... he... but I think...what happened is that I just become... so....used to it really...' [Ava: P:20. L:20].

One participant described a continuation of physical violence from her adult sibling when returning to the family home.

'...my brother's a bully and he's still around... you know... The last time I went up there he was hitting me and I had to get the Police out... you know...' [Sophia: P:25. L:27].

Physical abuse outside the home was less common in adulthood. There is mention of threats and some male posturing with other adults but only two accounts of violence. One involved Amelia during an ongoing feud with a neighbour.

'...trying to pick my daughter up and another Mother has got me around the throat, screaming in my face... and even the school are too scared to stand up to this woman... Errrm... You know... I kind of like... 'Why...?' 'You saw it happen and you won't even say it happened...' and they were like, 'No... well we have to stay neutral' I said, 'how neutral was that? You saw her walk over to me, put her hands around my throat...' [Amelia: P:15. L:2].

The other is an account of a heavy-handed police encounter, described by Evie.

'...Police were called to the house. I was thinking they had come to help, but found myself being 'put to the floor' in the kitchen by them, face down with arms handcuffed behind my back. The handcuffs made my wrists bleed. I was also humiliated in the van by being prodded by a truncheon as I was transported to the station. On arrival, I had to stand with my hands against the wall and legs spread whilst being searched and then left in a cell.' [Evie: P:2. L:22].

Emotional Abuse: 'Hurt more to be called names': Of the abuses described by the participants, emotional was experienced the most. As with the child abuses discussed so far, emotional abuse was highlighted as occurring in the family and at school with peers and teachers. The range of incidents includes being threatened, belittled, teased and called unpleasant names. Participants identified these experiences as pervasive; having the potential to cause psychological harm and a humiliation that is long-lasting. In the following short extract, Oscar provides an indication of the derogatory nature of the insults.

'My Dad used to put me up the wall and call me a dunce... A Dunce, Dad used to call me a dunce... He said you're no good...' [Oscar: P:6. L:21].

Disparaging remarks from a parent were familiar for a number of participants. Isabelle explains her experience.

'Huhhh (sigh)... I just felt a total failure in the end... I just didn't... like... I'd always felt that I was err, not want... well not, not wanted but the failure of the family and I got told, yeah, I am the failure... for a long time... (Int: How long..?) Pheew, until I was sort of sixteen, seventeen... all of my childhood... because I DIDN'T perform.' [Isabelle: P:35. L:16].

Amelia describes the psychological impact of her brother destroying her dreams.

'...he broke my heart, 'cause he turned round and said that I'd never be... I mean, you've got to understand that I was a little girl... and erm... weddings were something that you dream about... He told me that I would never be able to wear a white dress because obviously he'd taken my virginity... which I didn't really understand at the time... Errm and errr... he absolutely broke my heart over it. That was it... my world had ended...' [Amelia: P:26. L:30]

Emotional abuse is conveyed as occurring on a constant basis. None more so than the ongoing, persistent bullying that occurred at school. As with physical abuse, a number of participants describe the constant threat of emotional abuse from peers on a daily basis. Some stated this form of emotional torment hurt more than physical abuse.

'...In fact it probably hurt more to be called names, than it did to be pushed down the stairs...' [Scarlett: P:14. L2].

It also had an intensity, which is illustrated by a succinct extract provided by Amelia.

'(Bullied) All the time... Always! (Insistence in her voice)... Every day. I don't remember a day through my childhood... through my school years, where I wasn't teased... or bullied...' [Amelia: P:33. L:6].

The same level of bullying is reiterated by Freddie.

'Harrf, Ohhhh, I was always the incredibly short, shy kid with the silly curly hair and the incredibly poor background... So... I always did a lot of work academically, always very shy, so I was bullied intensely... (Int: Ok... So, bullied intensely...) Mmm... Huh huh... pretty much... pretty much on a daily basis...' [Freddie: P:17. L:7].

School children were depicted as cruel, but this also extended to school teachers. They are identified as negative and belittling to some participants. For example, Sophia recalls how the teachers responded to her.

'I was being belittled by the teachers because I'd been truant, so they didn't want to spend any time with me... helping me catch up... you know, with my education...' [Sophia: P:43. L:31].

Amelia describes her experience in a way that appears more personal as she identifies the insults.

'...teachers and everything said... you know, 'you're thick'... 'you're stupid'... you know, all those things that were horrible and negative...' [Amelia: P:9. L:21].

There is evidence that most participants experienced emotional abuse in both childhood and adulthood. The psychological harm in adulthood is analogous including, name-calling, belittling and being threatened or intimidated. Participants detail familial circumstances of abusive parents replaced by abusive partners and even their children. For example, there were accounts of emotional goading, insults and mockery within the family. Evie identifies the way her husband treated her.

'...the name calling was... was horrible and I can't remember the exact... you know... loony, words like this... and things... and it was in front of the children as well... which was pretty awful...' [Evie: P:20. L:18].

Then her children started to bully.

'...the children then started bullying me... You know... it was all quite nasty...' [Evie: P:25. L:13].

Others explained how they felt threatened by their partner. In the following extract, Sophia highlights her experience following a breakup.

'...he (Husband) was always bullying me... you know... all around when we split... and threatening me and his family were threatening me...horrible, nasty, you know what I mean? Wanting to kill me and saying nasty things to me. I was scared to open the door, you know to let my son go with him...' [Sophia: P:61. L:26].

Emotional abuse is also prevalent from peers and neighbours. One participant had problems with local school children in an isolated episode of what he described as 'cheek'. Participants shared incidents involving being shouted at, humiliated and picked on in various settings

outside the home. An example is discussed by Poppy, who is harassed by local people. In this short extract, Poppy shares her vulnerability to peers.

'...I got some of the people I know... around [Locality Redacted]... they pick on me as well... And... the one person who picks on me... I can't actually name...he has actually been arrested quite a few times by the Police... (Int: For that? Harassing you?) For actually harassing me...' [Poppy: P:12. L:28].

Some participants have problems with neighbours. Here, Amelia details events that are reminiscent of her experience of childhood bullying.

'So... it started off with the phone calls and then... there was a bit of verbal stuff going on in the street... errrm... Just name calling and sort of... errrm, you know... you know, things like, you know, 'they should cart you off to the Lunatic Asylum'. You know, 'you're stupid' 'you're thick'. You know, all that sort of negative stuff that, you know... usually hangs around the school playground, but she'd brought it into her adult life...' [Amelia: P:14. L:13].

Participants also identified incidents of emotional trauma that involved medical services, police, employers and religious groups. For example, they describe being belittled and humiliated by people in authority. This is illustrated by Ava when attending a routine appointment with her GP.

'I did have an experience with one of the GPs in the practice who... I do cut myself...who was quite...basically, 'a woman of your age shouldn't be doing this...that's for teenagers'. And the subsequent attitude from that... was quite hard...' [Ava: P:26. L:9].

William identifies a similar experience when seeing his psychiatrist.

'(Psychiatrist) as I was sitting down said, 'who do you think is talking about you now..?' I was stuttering... I thought he thinks I'm paranoid... before I've opened my mouth... I mean, it beggars belief...' [William: P:49. L:6].

Witness to Domestic Violence: 'Dad hit my Mum': Being a witness to domestic violence was experienced by a number of participants in childhood. They recollect being placed at the fringes of violent incidents involving their parents fighting each other. Incidents included arguments and shouting, resulting in physical violence. This is illustrated in the following extract from Freddie.

'Harrrrf (catching breath), but yeah... There was... yeah, lots of anger and lots of shouting... Harrrf, yes, there was physical violence... sometimes... and... (Int: Towards you?) Yeah... harrf, but to be honest, I think I got away with things pretty lightly comp... I always thought my Mum got it pretty bad...' [Freddie: P:10. L:14].

Once mentioned in the interview, no participant elaborated on the experience or invited further discussion. Here, Noah provides some context regarding the violent behaviour.

'He (Dad) used to come in every night boozed up... He was an alcoholic he was... Well my Dad used to hit my Mum (pause)...' [Noah: P:21. L:26].

In a similar extract, Sophia mentions the periodic violence in the home.

'They (parents) used to argue sometimes and sometimes have violent fights... errrm, shouting...' [Sophia: P:40. L:18].

Financial Abuse: 'Just coining me': Financial abuse, as defined by the Law Society (2013) was experienced by the majority of participants, but in adulthood only. As it is not a childhood experience, its presence identifies the breadth of abusive encounters and misfortune that befalls some participants. They explore incidents of partners and friends taking advantage of their vulnerability, manipulating their lack of social awareness, pestering for money and even emotionally blackmailing for financial gain. Here, William talks of emotional manipulation.

'She, she (Partner) was stringing me along a bit...you know, saying she loves me... only when she's in prison, to get money out of me and that... just coining me...' [William: P:16. L:18].

Others describe financial exploitation from partners, children and even employers. The first extract describes a double hurt.

'My second husband went off with a friend... that hurt badly... I was hurt with him going off and, hurt with the debt he left us in...' [Isla: P:27. L:5].

The second extract is provided by Sophia explaining the financial situation with her son.

'...they (son and girlfriend) ran the bills up and stuff...and he wouldn't pay... you know... towards their keep (rent) out of the money they'd got... I never did get much money

and I weren't asking for much... they didn't... they just left me with everything to pay myself...' [Sophia: P:59. L:11].

In this third extract, Isabelle explains her experience of a fraudulent employer.

'He took all our national insurance money off us, you know, at source... (Int: Mmm) ...out of our wages, but he never paid it to the national insurance people... (Int: Right...) After a year... we all got letters that we owed...a lot of money...' [Isabelle: P:16. L:9].

Neglect: 'I didn't really feel like there was anybody, there was just me'

All forms of neglect were present in participant accounts of childhood. The experience of neglect was interpreted from passive neglect through to severe deprivation. Examples of parental neglect were identified as a lack of care and protection for their development and well being. Practically, this involved neglect with regards to food, clothing, personal hygiene, and so on. Emotionally, they lacked love, attention and interest in their welfare during periods of need, illness and concern. Ava provides an illustration.

'...I was only 11 and half pounds when I was 9 months old... and it was only my Mum going to stay with my Grandparents... and my Grandparents who fed me up... so it started off badly... Ha ha (laugh).' [Ava: P:12. L:36].

Some described lacking a tangible experience of love from family or others. Ella identifies this within her succinct extract.

'The only love I ever really had was from the dog... (Int: Mmm) I never felt any love from anyone else... I wasn't really allowed to... have many friends... or go out, apart from with the family, so it was very like... we didn't have that much contact a lot of time, with... the wider family and when I did it was quite abusive...' [Ella: P:20. L:13].

Others described poor living conditions, where the home was a physical manifestation of their neglect.

'I suppose the house we grew up in... I grew up in...Huh... (sigh)...well actually you wouldn't put animals in there... it was really bad... Errm, it wasn't Mum's fault... she worked as well, you know, she'd do cleaning for a couple of days a week... and then five days a week, she helped clean out a school... So... errrm, it really wasn't her fault... Errrm, but the house was an absolute slum... It was just... yeah... errm, (visibly and vocally upset, emotional, hesitant, thoughtful... Not tearful)...Washing up only got done

when there were no plates left...Yeah, there was just stuff everywhere, 'cause you could imagine eight people in a two bedroom house...' [Amelia: P:25. L:10].

In the extract, Amelia mentions living in two-bedroom house. This shows an element of neglect on the part of outside agencies such as social housing. For example, Amelia describes the unsuitable accommodation further.

'We were in a two bedroom house... there were six of us in one bedroom... mixed... boys and girls... So I was thirteen and my brother was twenty one/twenty two... That was the environment, so you know... very poor, very poor family...' [Amelia: P:24. L:22].

There was evidence of neglect into adulthood too. Rather than family, participants described housing or health services not understanding or acknowledging their level of vulnerability. This is illustrated by Isabelle, who shares an incident involving the loss of her medical notes when applying for emergency accommodation.

'My papers all got lost...and everybody said, well... you're not on anything, so you're not a vulnerable person, you're not nothing... So we ended up homeless...' [Isabelle: P:14. L:21].

With regards to health services, Sophia describes her vulnerability during an impersonal discharge from a general hospital.

'...when you go to hospital, they don't care for your needs... it's just a case of that you're in and out... they're not checking out whether you've got anyone or not... I remember having to catch a bus home in my nighty and dressing gown... you know, after the first time I'd been in... and they were just dismissing me and saying there was nothing wrong with me.' [Sophia: P:22. L:18].

Other participants detail neglect from services not fulfilling their offers of help. Here, Isla shares her feelings.

'People think they're helping you, but they're not... they make you worse... (Int: In what way..?) Promising you'll get this done and this and that...and nothing ever happens and that makes you worse...' [Isla: P:28. L:18].

Superordinate Theme 2: The Disbelief of Rejection

Rejection emerged as separate from the experience of maltreatment. It was specific and described with a level of disbelief. Most participants experienced rejection across the lifecourse; including marginalisation within their own homes, at school and from agencies meant to help. This theme can be interpreted in three key subordinate themes; namely, **Disregarded, Loss and Stigma**.

Disregarded: 'We were left in America'

Being disregarded was reported by all participants. As seen in Table (10.1), it is experienced across both childhood and adulthood. Accounts identify disregard as a deliberate act to undermine contribution, protest, or having a voice. This entailed being ignored, dismissed and abandoned. Such disregard for the participant denied their involvement inside and outside the home; with family, friends and outside agencies all contributing to this.

The following extract provides a familial context of being dismissed. Amelia attempts to seek guidance from her mother regarding the experience of sexual abuse as a seven year old child.

'I remember him coming home drunk one evening...and get into bed with me and my sister... and I... You know, things happened that shouldn't have happened. I said, 'Mum...?' 'Oh well he just got drunk, just ignore it...'. Do you know what I mean... It was just accepted... it was brushed under the carpet... 'this isn't happening'...' [Amelia: P:40. L:17].

Another participant shares her lack of options for help as a child suffering abuse.

'I wasn't... really given any opportunities to ask for help, or if I should ask for help, or you know, who to ask...' [Ella: P:20. L:23].

Abandonment was another aspect discussed. This form of disregard is interpreted as lacking acknowledgement of their needs. Although similar to neglect, it is experienced in a more overt way. An example is highlighted here by Ava. She describes being almost discarded by her parents in the USA.

'...my Dad went to Jamaica for three months and Mum wanted to go... so...me and my sister... I was six... fifteen... with my sister... we were left with somebody in America...

in [State Redacted]... that they knew a bit... but didn't really know... and just left... left us... my Dad and my Mum went off ha ha (laugh)...' [Ava: P:15. L:20].

Another participant identifies a sense of abandonment when moved from the family home as a small child.

'You see my Mom took ill... and... I got moved... up to a village in [Name redacted] to live with Auntie and Nana... and I always thought I was going back home again.' [Isla: P:22. L:17].

The experience of disregard is also described through events at school. Participants highlight incidents of their opinion or even presence being explicitly ignored. They recount feeling disliked by peers and teachers alike. For example, Scarlett illustrates how she was received by peers in school.

'(Sigh)... It wasn't like I didn't get on with them... they just didn't like me...' [Scarlett: P:12. L:26].

Noah shares a similar experience of feeling disliked, but by his headmaster.

'The headmaster... He didn't like me... Mr. [Name redacted] is name is... then Mr. [Name redacted]... (Int: How did you know he didn't like you?) I just think he don't... That's all I can tell you...' [Noah: P:23. L:9].

In addition, some participants described a lack of intervention from school teachers when they were made aware of bullying. Freddie is resigned to the lack of support received.

'(Int: Did you ever go to the teachers?) 'Ohhhh... I did, once or twice... nothing really changed... so I gave up on it...' [Freddie: P:34. L:10].

This is comparable to an account from Sophia, highlighting disregard from the headmistress. The incident specifically relates to her account of boys chasing her for a sexual experience (see Sexual Abuse).

'...the headmistress... she was a new headmistress at school... in the Senior school...and she didn't deal with it very well and say, oh well it's a bit of horse play...you know, very dismissive of it...' [Sophia: P:43. L:23].

In adulthood, disregard was evident from family members through to outside agencies. This included partners, children, health services and the police. Such rejection was commonplace, involving a deliberate lack of interest, lack of communication or lack of regard for their welfare. For example, disregard appeared a continuation of trauma within relationships across the lifecourse. Some partners had extra-marital affairs, others withdrew connection. In the following account, Evie shares poignant events in her marriage.

'... he was... by that time he was having an affair... but he was pretending he was being a kind husband... so he was coming home, going round her house for his dinner, then coming back at night... by that time we weren't sleeping together... I was banished to the floor downstairs... [Evie: P:29. L:28].

In another account, Jacob conveys frustration with the lack of response in his relationship.

'But with her... I got no input...you know... I'd tell her what I want and ask her what she wants or wanted from me... or what... and I'd get no answer... (pause)... errrm, I suppose that upset me more than anything... cause... I didn't know an answer to a problem... [Jacob: P:30. L:26].

Disregard was also adopted by some of the children of participants too. For instance, as the children became teenagers they rejected input and guidance from participants. As Sophia explains, she is in disbelief with the deliberate rejection from her son.

'... and they (son and his girlfriend) moved out when I went to help my parents and stuff... and take them on holiday and that... and... I was looking after them and they moved out behind my back... and I hadn't any contact, so I didn't know where they lived... They wouldn't tell me where they lived... [Sophia: P:59. L:21].

Others experience a different type of rejection from their children.

'Even when past events are mentioned they (children) actually witnessed, they deny it happened and 'idealise' their father.' [Evie: P:3. L:1]. From Interview Notes.

Disregard from outside agencies in adulthood provided a rich source of material generated by the participants. They spoke of experiencing ineffective services across all aspects of medical and social care. Generally accounts identify a lack of assistance. Services are seen as negative and creating barriers specifically for them. This was detailed with regards to appointments, treatment, and engagement and so on. For instance, some feel rejection from agencies such as

primary care, mental health services, and the police. Here William highlights an encounter with a psychiatrist.

'Other times I've been on my own and this Indian doctor gave me about a minute and I'd been waiting an hour...He said to me, 'you're late' I said, 'no I've been waiting an hour for you' and he seen me for a minute and a half... so I didn't see him the next time... I thought, 'what is the point of going all the way down there for a minute and a half'. He never even give me... yeah, it was a minute and a half he did.' [William: P:49. L:11].

Another account details rejection felt from mental health services. Sophia provides a candid assessment of her experience.

'I've had appointments like that, where I've gone and they refer you to a community psychiatric nurse and you've waited months and months and months to see someone... and then they'll say, 'well we've seen you before'... you know... a few years back... (Int: Mmm) You know... 'there's nothing we can do for you..' you know... and they're just like, not engaged with taking you on in their services and kind of just got rid of you really...' [Sophia: P:29. L:27].

Participant concerns regarding the police incorporated feeling they were dismissive and disinterested in their complaints. An example from Noah highlights his anger at the lack of progress with his case (victim of robbery).

'They (Police) ain't done nothing about all this... They've done sod all about it... (pause)... I haven't gone back you know. I'm not happy with the Police... (Int: You're not happy with them..?) I'm not happy with them...' [Noah: P:4. L:1].

Other participants directly link police disinterest with their mental health status. For example, William feels sure the police withdraw from his complaint of intimidation against a fellow attendee at a day service because of his diagnosis.

'I brought him (police officer) up here (local mental health charity) and err, the police didn't want to know... he didn't want to know...you know, the copper didn't want to know really... You know, but errrm, he asked me what this place was and I told him...and he wanted to know what I was diagnosed and I told him I'm a paranoid schizophrenic... and it goes against you... I know that, but I mean he didn't want to know, the copper...and errr, he wrote down in his report that I didn't want action taken... I DID... I just wanted this bloke to have a caution...and I phoned up [Local Police Station]... They didn't help me, they didn't help me...' [William: P:43. L:2].

Loss: 'He was never there'

The experience of loss was identified by a number of participants and is interpreted in two distinct subthemes of death and familial absence. It emerged that the context of the subtheme death entailed the loss of a parent in childhood or a partner in adulthood. The subtheme familial absence incorporated a range of events including either physical or emotional absence of a family member, or childhood absence due to long-term hospital stay.

Death: 'Hit me for six': The experience of loss through death was mentioned by a third of the participants. The significant events involved the death of parent/s or a partner. The experiences are conveyed with sadness and recognition of their profound impact for some. When death is mentioned, often the account intimates a perception of influence or blame. For example, Jacob identifies early in the interview that his mother died young.

'Me Mother died when I was errr, 15, 16. (pause..) (Int: Ok...) (long pause...) Sort of thing I've got to errr... go through my own life... as the saying goes... school of hard knocks... (ha ha ha...laugh).....' [Jacob: P:6. L:5].

Later he shares his feelings of responsibility.

'I pestered her... then she was taken into hospital and died... And I suppose to a certain degree, I blame myself for it...' [Jacob: P:20. L:7].

In another account, Isla details the loss of both parents before the age of ten years old. She hints at a connection between her accident and death of her father. Although it reads as a matter-of-fact, it was conveyed with great sorrow.

'My parents died when I was young... my Dad died when I was... five... because I just started school in the October and in the November got hit by a firework rocket in my neck (points to the left side of her neck). And it was touch and go for over five years, but when that happened to me, my Dad got worse and he died. Then my Mom died when I was nine... (pause) with cancer... (pause)' [Isla: P:4. L:12].

In adulthood, death of a partner was experienced and loss of parents mentioned. Such events highlight the significance of death across the lifecourse. In the following extract, Poppy talks through the night her husband died with a similar hint of influence.

'...He said he couldn't make it home... and I didn't take much notice of it... turned 'round to say something to him and he just went completely white... so I said to the cab driver, 'turn back round please and just take us down to the hospital... and he died of a heart attack on that night...' [Poppy: P:2. L:30].

Death of a parent was mentioned by some participants. As with Ella, this experience was incredibly difficult in light of unresolved past events.

'I just didn't feel strong enough to deal with it... and I did really struggle with my father's death... (Int: Mmm) But I hadn't been having counselling... at that time, for a couple of years... and I did go back in to see a counsellor... but I struggled... it was like having unfinished business...' [Ella: P:21. L:35].

Familial Absence: 'I never really knew my Dad': Absence was only described in familial terms. The absence discussed in childhood was that of a parent. This entailed emotional absence of a mother, but mainly the physical absence of the father from their young life. Key reasons were work or parental separation. Several participants conveyed examples with a sense of loss. The parent is absent all day, for months at a time or all of the time. This appeared to be interpreted as a choice, leaving the child puzzled and bereft. An example of emotional absence is portrayed here by Ava.

'She's (Mum) not somebody I could have gone and hugged or...gone and talked to about a problem or anything... so any problem I would keep to myself... you know...' [Ava: P:14. L:13].

Physical absence is considered here in an extract from Jacob.

'... oh we got on alright... (long pause)... He (Dad) worked for... well most of the time... so I didn't see him for my younger years...' [Jacob: P:20. L:18].

This is reiterated by Scarlett and her experience of absence influencing the relationship she has with her father.

'I had a good relationship with my Mum...we were very close... my Dad not so much... but I think that's because I didn't see him a lot... and... he was never there... he was always away fighting (armed forces) and stuff...' [Scarlett: P8. L:12].

In adulthood, familial absence is experienced through deliberate separation, detachment and a lack of acknowledgement that reinforces distance. Often this is experienced at vulnerable stages of life or indeed highlights vulnerability. For example, Isabelle identifies her experience of parental absence. The powerful extract is very clear, but what is not evident is that this was during an extremely difficult period in her life.

'My parents didn't even care really, whether I was alive or not... and what was really going on with me...' [Isabelle: P:14. L:1].

In addition, some participants are estranged from their family and have difficulty establishing contact. This is highlighted by Ella and her attempt to gain information about the death of her father.

'I wrote to ask... what the circumstances had been and could I have my sister's address and... to try and keep in contact, she sent a letter through a solicitor... saying that she didn't want to see me and... could... wouldn't tell me how my father had died... and she wouldn't give me my sister's details... When that happened I just felt that, to continue contact, with me risking more solicitor letters, and... it wasn't worth it... So that was the last contact I had...' [Ella: P:21. L:19].

This is similar to Sophia and her estranged son.

'Errrm, my son left and he hasn't stayed in contact with me... So I've had a lot of rejection, you know... off people... over the years...' [Sophia: P:19. L:28].

The situation is not confined to parents and children. Here, Poppy describes the absence of her grandchildren from her life. Poppy highlights her knowledge of them through both sorrow and humour.

'... Yeah, she's (daughter)... on the first set of twins they are a boy and girl... they're four this year... second set of twins are eight months old next Wednesday... And I haven't seen none of them yet... ha ha (chuckle)...' [Poppy: P:7. L:7].

Stigma: 'I'm walking in with a label'

Stigma was identified by a number of participants relating to mental health problems in adulthood only. It occurs both in the home and identified within services such as health and social care. Stigma from family was reported to involve males only, whether a father, a partner

or a male child. Perceptions of 'mental illness' were derogatory, crude and damning. Fathers are perceived as hurtful and insulting, partners taunt and goad, children appear to resent and disrespect. An example is provided by Isabelle.

'His (Dad) perception of mental illness... He had no perception... To him it was the... you might as well not be my daughter... any more... he threw a lot at my partner... They said, 'You've caused my daughter to be like this...' (Int: Your husband?) Yeah... things like that... So they threw it all at him... and they... totally disowned me...' [Isabelle: P:9. L:33].

Poppy highlights how her mother has made her feel like a specific type of outsider.

'I was always treated as the black sheep of the family...' [Poppy: P:16. L:2].

This view is reiterated by William talking about how his father makes him feel.

'...even your own family hold it against you... We are the black sheep of the family... lowest of the low...' [William: P:14. L:1].

He later adds more detail.

'It's a bit of a stigma being ill... A stigma... it is... I told you what I... (Int: Stigma?) Yeah, stigma... (unclear)... even my own Dad said to me... when people ask what I'm doing... he has to say... he can't say... 'He's doolally tap down the centre...' You know what I mean... they're all crazy down the centre...' [William: P:27. L:27].

Stigma can also go beyond name-calling. In the following extract, Evie describes the form of stigma directed by her husband in front of her children. In addition they were told not to talk to her.

'Errrm, by that time he was telling horrendous lies... errr, to the children, errr to anybody that would listen... And he seemed to think that I was some kind of... threat to my children... because I was... Mentally Ill... Errrm, and he made... He made locks for the children's doors...' [Evie: P:28. L:20].

Stigma also extended outside the family. Some incidents included employers, but mainly agencies such as health services, police, and mental health charities. They describe being treated differently to others, not being listened to, having rights violated, being treated with

suspicion and labelled. Within the workplace, two extremes are depicted through either public humiliation or exclusion. The first is evident in the account of Isabelle, who suffers public protests from colleagues aware of her mental health problems.

'I'm not working with somebody who's mad...' 'How dare you be here, 'cause you're mad' (stated in quiet and sombre way)... And then it got... into the realms of... She used to tell the other people... 'She's mad'...' [Isabelle: P:20. L:24].

The second is experienced by Ella, but through an opposite reaction.

'My main stigma I had... you know all the people I'd worked with or trained with, never spoke to me again, even if I saw them...(Int: Mmm) So there's a lot of stigmatisation... (pause)... You know, they wouldn't talk to me at all... and... it was as though they thought they could catch whatever they thought I had, from me...' [Ella: P:30. L:30].

A number of participants report stigma from outside agencies. This is often felt as unexpected and unwarranted from services they attend for support. An example is provided by Ava who attended a hospital appointment for a physical condition.

*'I went back to the hospital... with like, you know... maybe I had another DVT (Deep Vain Thrombosis)... is that... on the top of the letter... or the notes about... Had got... in capital letters, the whole lot... **PERSONALITY DISORDER** across the top... and I found that quite challenging... because... you know... it was that diagnosis was prior to the DVT and that in the summer... Yet the top of my things has it like that... That made me very much feel... that I'm walking in with a label... you know... in that people would see that first... rather than... why I was there...' [Ava: P:25. L:28].*

Others believe they are treated unfairly as a result of their mental health problem. For example, William indicates a lack of basic rights from services he has complained about.

'It's because I've got mental health problems... They haven't even given me basic rights... Well they can hide behind your mental health problems... like with social services and local mental health charity, they didn't give me my basic rights...' [William: P:12. L:28].

Finally, Amelia provides a troubling insight into her experience in court. She is pursuing a case against an intimidating neighbour, but describes her mental health history being used against her.

'So it was probably around... '98, '99... that sort of time... Even then... They got away in court with referring to me, as a lunatic... you know... you know... and I just thought... and her lawyer... I remember... her lawyer kind of like addressing the bench and sort of saying... you know... this woman is not safe to be on our streets... She should be locked up in the Lunatic Asylum...' [Amelia: P:16. L:8].

Superordinate Theme 3: Powerlessness of Family Life

Powerlessness was a feature that emerged from the majority of the sample. Although examples have been illustrated throughout this chapter, this theme specifically focuses on: **Restricted by Control and Familial Influence**. Each subordinate theme illustrates experiences of being powerless to the influence of family. For example, parents dominate through fear, restrict movement and negatively influence participants through poor life choices.

Restricted by Control: 'I didn't have freedom'

This subordinate theme was evident in the lives of participants where their parent/s dominated decision-making and controlled everything. Incidents included restriction with leaving the home, using public transport and so on. Other aspects of control emerged as the restriction of access to others, opportunity to play and having unreasonable responsibility for siblings. An illustration of control is provided by Isabelle.

'... it was a happy childhood. I was loved... but... if my father said jump off the roof, I would have done... He was very domineering... and things...' [Isabelle: P:34. L:31].

Some describe control of their movement.

'I mean, my parents didn't let me use public transport that much, and they weren't that keen to transport me anywhere... so... or let me go anywhere... So it was very restricted...' [Ella: P:28. L:8].

For others, the level of restriction was intense and somewhat debilitating. Oscar provides insight into his experience.

'My Dad would have me in my pyjamas at six o'clock and bath me at half five (5.30pm)... and pyjamas at six o'clock... make me stay in the house sitting?? But I used to be scared of the door with my pyjamas 'cause I was embarrassed... and he made us... he made us put my 'jamas on by six o'clock...made us have our dinner all of the time when we wanted to play out... all the kids played out...playing in their garden. I

used to stare out of my bedroom window looking at them all playing...' [Oscar: P:13. L:12].

Restrictions also extended to include responsibility for siblings. Sophia provides an account of caring for her sister who is severely brain damaged.

'I was always expected to watch over her... and make sure she didn't do anything... you know, that she shouldn't. Which was kind of impossible really... because of the nature of the way she is...' [Sophia: P:31. L:34].

Restricted by control is also reported in adulthood. Participants found that circumstances continued through parents and partners. Examples were spread across a range of events such as control of mobility, autonomy, restricted access to family, reduced communication and so on. Indeed, Poppy discusses a difficult situation with her mother, whereby she must leave her child and move out of the home. She identifies her epilepsy as a contributing factor.

'You know, if I had had a fit, say I was walking down on the path with the baby in the pram...and I'd had a fit and...the pram went over... she said, 'you are not taking the baby, 'cause I'm thinking of the baby's health...' She said, 'the baby can stay here but you can still come and see her...' So I still kept in close contact with my daughter anyway...' [Poppy: P:18. L:10].

For Sophia, it was a situation unchanged with her mother.

'She just dominates... she's still domineering now you know...' [Sophia: P:35. L:8].

Others reported having controlling partners replace controlling parents. This is illustrated by Ava, whose description also incorporated humour.

'...Huh (sigh)... he was an alcoholic... he was very controlling... of me... I just literally had two weeks off from being with my Mum and Dad to moving basically... suddenly being in the same situation...' [Ava: P:20. L:1].

Familial Influence: 'It wasn't particularly normal'

Familial influence amalgamates a range of events significant in the life of over half the participants. Such events influenced their home life through uncertainty, instability and altered landscape of the home environment. For example, parental illness or lifestyle choice of parents

such as divorce, unpopular or multiple marriages, house/school moves and so on. The following extract shares insight into Scarlett's home life with an alcoholic mother.

'...my Mum was an alcohol... well... I, I, I... she never went to alcohol services or anything, but I would say she was an alcoholic... She used to drink a litre of Brandy every day...' [Scarlett: P:9. L:15].

Other participants discussed the influential event of parents separating, divorcing and remarriage. In the following extract and interview, James offers insight into a traumatic event but has no wish to elaborate.

'Not bad, not brilliant... (childhood) it was ok (said quietly). It was... it's alright, my parents divorced when I was fourteen...' [James: P:16. L:5].

Poppy provides an overview of instability in her home environment.

'Huh huh (laugh) My Mum married quite a few times ha ha... (Int: Right...) I think she was trying to do an Elizabeth Taylor... ha ha. She married about... I think it was about seven times... she remarried again... (Int: Was there any that you got on with?) Errm, not really... I sort of just took it as it came, 'cause once I got used to the one... then she'd get divorced from him and then married another... (Int: Right...) Once I got used to that one, she'd divorce that one and onto another...' [Poppy: P:18. L:17].

Moving schools was identified by some as influential. Here, Oscar shares the experience of changing schools based on religion. He appears propelled into a dichotomy that involved religions, schools, and friends.

'I went to Protestant school at junior school, then I went to senior school as a Catholic... I didn't know anyone in that school apart from one girl who went to my old school... who moved from my old school to my new school... all my old friends went to [Protestant Senior school] and I went to [Catholic Senior school]... I tried to be clever... I tried to be something that I wasn't...' [Oscar: P:14. L:19].

For Freddie, the experience of moving schools was focused on separation from his siblings.

'...even though there was just a year's different age to my... to my sister and... I'm two years younger than my brother... you know... we quite often went to different schools because we moved round quite a bit... and so, yeah it was quite often I wasn't at the same school as them...' [Freddie: P:19. L:8].

In adulthood, there is limited evidence of continued familial influence with regards this subtheme. However, one participant does stand out with regards to moving home with seemingly little choice. Here, Amelia describes escaping a gang threat instigated by the actions of her son. Although she stands up to the gang she is forced to flee to a new city.

'...but because they (gang) couldn't get after him (son), they targeted us as a family... so the kids couldn't walk to school on their own... They couldn't go out, I couldn't go out on my own... There was frequently a Police Officer, you know... sat in the car outside... it was a Thursday night, these guys came round, I had no idea at the time that they'd come tooled up with knives and what have you... and they came round looking for [sons name redacted]... and he wasn't there... So anyway, they kind of like came round and I kind of like stood there and I said, 'well, if you want him, you're just going to have to come through me'... Which wouldn't have done their street 'cred' any good... thankfully (laughing)... and they went off and it was later on we found out they'd been 'tooled' up. So the next day, we literally fled...because we'd heard that a price had been put on the family's head...' [Amelia: P:12. L:20].

Summary

The nature of traumatic experience has provided indications, insights and powerful acknowledgement of the lived experience of trauma. Such incidents in childhood are often emotional, uncomfortable, or brutal in their description. The breadth and depth of trauma endured is evident. It is found in their home life, familial relationships and social connections across the lifecourse. An ability to cope with such events is the subject of the next chapter: Coping and Adaptation to Childhood Trauma.

Chapter 11

Coping and Adaptation to Childhood Trauma

The second master theme to emerge from the findings is **Coping and Adaptation to Childhood Trauma**. The previous chapter identified the traumatic events participants have experienced. This chapter will provide an insight into the way participants attempt to cope and adapt to their lived experience of trauma. Coping is defined here as efforts to prevent or diminish threat, harm, distress, and loss (Carver and Connor-Smith 2010). This is regardless of voluntary volition or involuntary response to stress (Compas et al. 2001; Skinner and Zimmer-Gembeck 2007).

Three superordinate themes emerged, including **Protection**, **Repressive Coping** and **Retaliation**. They are presented in Table 11.1 with their subordinate themes. The key provides a visual overview that illustrates whether coping is experienced as a child, adult or across both. Some are specific to the distinction of age and circumstance. For example, **Environmental** is only identified in adulthood, because it can only be influenced in adulthood.

As with the nature of traumatic experience, each superordinate theme provides participant experience across the lifespan. Both child and adult accounts will be discussed under each theme but considered separately. Coping strategies are identified, with some not immediately apparent as advantageous (Bonanno 2005). For example, repressive coping might seem maladaptive under normal circumstances but can have adaptive benefits (Mancini and Bonanno 2009).

Table 11.1: Cross Case Identification of Recurrent Themes: Coping and Adaptation to Childhood Trauma

Themes			Participants														Present in over half of the sample		
Master Theme	Superordinate Theme	Subordinate Themes	Isla	Jacob	Ameilia	Ava	Poppy	Oscar	Sophia	William	Jamies	Noah	Eve	Ellie	Scarlett	Isabelle		Freddie	
Coping and Adaptation to Childhood Trauma	Protection	Seeking Support	√	X	X	X	X	X	X	X	X	O	O	X	X	X	X	Yes	
		Active Avoidance	X	X	X	X			√	X	X	O	O	X	X	X	X	Yes	
		Environmental: <i>Home Security</i> <i>Neighbourhood</i>	O	O	O	O	O				O		O						No
	Repressive Coping	Engage with friends	√		X	√	X				√		√	X	X	√	√	O	Yes
		Activity		O	O	X	O	O	O	X	√	X	O	X	X	X	X	O	Yes
		Sensemaking		O	X	√	X	O	X	√	O		O	X	X	O	X		Yes
		Self-enhancement	O	O	O	X	O						O	O	X	X	X		Yes
	Retaliation	Against Self	O	O	√	O	O	O	√	O		O	O	O	O				Yes
		Against Others:	O	X	√	√	√	X	X		X	O		√	√	O	O		Yes

Key:
√ = Childhood,
O = Adulthood,
X = Both child and adulthood

Superordinate Theme 1: Protection

The superordinate theme of protection was identified by the majority of participants in childhood and all participants in adulthood as an important coping mechanism. The theme is broken down into three subordinate themes that include **Seeking Support**, **Active Avoidance** and **Environmental**.

Seeking Support: ‘Tried to tell my Mum’

Attempts to seek support were discussed by the majority of participants and identified across both childhood and adulthood (Table 11.1). In childhood the theme mainly emerged as the actual seeking of support and participant perception of support received. The views shared are primarily based on unsuccessful attempts to gain support. Participants are often left to deal with traumatic experience alone. As a result, many settle for basic care and periods away from the traumatic home environment as a measure of successful support.

Some participants attempt to balance their traumatic childhood experience with a positive outlook of stability. When reflecting they provide a definite demarcation of what they consider loving or acceptable. For example, having basic needs met such as food and clothing hold importance. Others reflect on the basis that it could have been worse. Here, Isabelle has a succinct definition.

'You know, you can't... you never... It was always a loving family 'cause we always had food on the table.' [Isabelle: P:25. L:21].

Sophia presents a balanced reflection.

'I think she was a bit cruel sometimes...very cruel... always criticising, or what they call the over-critical parent ha ha ha (laugh)... she probably didn't mean any harm with it, it was just the way she was...we were fed and clothed, well not loads of clothes and toys and that...we weren't rich...just a working class background, but errm, you know... we always had good food on the table and she did her best...' [Sophia: P:36. L:2].

William provides an interesting appraisal.

'Well it weren't too bad, I mean I wasn't molested or anything like that sex... I know some people could have... I know it was a bit rough and tough...' [William: P:34. L:3].

In contrast, others did not have a positive perspective. They describe having no support at home or having little success accessing it. Here, Amelia describes unsuccessful efforts to engage her mother.

'I remember my... when my sister sort of tried to tell my Mum what was going on (sexual abuse)...but was making it out more... that we were putting ourselves about... I mean I was... Eight when it started maybe...' [Amelia: P:25. L:33].

Later in the interview Amelia adds to the description.

I just feel that... 'cause my Mum's quite limited in her understanding as well, I think she thought that actually me and my sister were choosing to put ourselves out there... Which wasn't the case at all...' [Amelia: P:27. L:5].

A more generic consideration of home life as a child is detailed by Freddie.

'I never felt like I had any kind of base... if you like... any kind of grounding and support...' [Freddie: P:8. L:11].

Some participants received support from extended family. Ava conveys her relief at spending holidays with her grandparents. Time spent away from the home provides an element of solace.

'I liked to go to my Grandparents and sort of went for one week in the holidays... Summer holidays... but I...they're... I couldn't have told them... but I did actually feel like a child when I was there...' [Ava: P:24. L:19].

In a similar extract, Amelia remembers her grandfather with fondness.

'Granddad lived just up the road...and he was my absolute rock... ermm, you know... He died when I was five, but he was just the centre of my earth, my World...' [Amelia: P:25. L:6].

Participants discussed school life as the main experience outside home. Unfortunately, for many, school provided further trauma. Therefore, seeking support from teachers was necessary. Some were sympathetic and intervened, others were less-inclined. The following extract highlights a supportive headmaster.

'...well I was alright at school until people started treating me with disrespect...and I got it a bit in Junior School when I was coming up to puberty...like sexual harassment off the boys in school, but that was dealt with appropriately... you know, the headmaster took it seriously...' [Sophia: P:42. L:22].

Similarly, Isla describes the support she felt from teachers following the death of her mother.

'...the staff and the headmaster just seem to got to know...that my Mom died... They were pretty good... I didn't have to do my lessons but they kept an eye on us...' [Isla: P:23. L:4].

However, many participants had a less favourable response at school. For example, Freddie provides a succinct appraisal of a lack of support.

'(Int: Did you ever go to the teachers?) Ohhhh... I did, once or twice... nothing really changed...' [Freddie: P: 34. L:10].

When the experience of seeking support is met with a poor response and outcome, repercussions can include a loss of trust. Scarlett recalls her experience and feelings.

'I told the teachers then...errrm, and we had a meeting. There was me, her (bully), her parents and my Mum. And the teachers... oh and there was my tutor and the head of year seven. Errrm, and there was a meeting where, 'this is what I said, this is what she said.' 'You've done this, you've done that' and then she denied it all. Then my Mum said, 'I'd like her to move tutor groups' and that was the end of that then and that's why I've never told anyone ever again, because nothing was actually done about it...' [Scarlett: P:15. L:16].

Evidence of seeking support in adulthood incorporates a wider range of opportunities. For example, support was gained through improved relationships. This included children giving a sense of purpose, parents becoming more tolerant and access to outside agencies. For example, Sophia shares her current relationship with her father. The difference conveyed is communication, time and perceived support via the telephone.

'I have a closer relationship... my Dad talks more to me now... that I'm older and he's retired and he's older... He talks to me more now on the phone than he ever did... when I was younger...' [Sophia: P:38. L:19].

Other participants describe their children as providing support due to the role and responsibility of parenthood. Ava shares her perception.

'...Yeah.... And they were the thing that kept me going really... the kids...' [Ava: P:25. L:19].

Seeking support from friends was mentioned by participants but generally limited. Friendships are often established through church or mental health services. Essentially, the sample seems unfamiliar with any reliance on friendships. However, Ella makes reference to her progress.

'Yeah... and I've got... when I was really struggling with my mental health issues... I did need professional support, but now, it's just like anyone else... having close friends...' [Ella: P:5. L:19].

William points out shared experience.

'...my friends are... they're all mentally ill...' [William: P:35. L:13].

Across adulthood seeking support was mainly centred on their experience of mental health problems. The sample was recruited from mental health charities and as such they all attend. This varies from daily drop-in, to support clubs, group work and so on. Others use local mental health services for community support or group therapy. These easily identified as the best source of support. This is highlighted by Isla in the following extract.

'Dr. [name redacted] I think his name was... transferred me here (Mental Health Charity)... for a place here (said positively). It's been the best thing... for me you know... (attending drop-in) cause I lost my home and my husband, and my job and everything. It's just all got on top of me, cause I couldn't work cause that's the only job I knew.'
[Isla: P:3. L:5].

Other agencies included the Police. Several participants had contact due to threats from peers, theft, and domestic violence. Response was mixed. As discussed in chapter 10, some participants do not have a good experience with police. However, others are extremely pleased with the support they receive. Amelia shares how the police reacted to her concern.

'...when we had the situation with the drug dealers...they (the Police) were fantastic... you know... I could phone and... somebody would be there within a couple of minutes... 'cause they knew... one they knew I wasn't very well, but two, they knew we were dealing with some pretty awful people... and often, they would be parked outside the house...' [Amelia: P:41. L:9].

In another extract, Poppy explains how she feels supported by the local police.

'...I'm well known... not as a bad thing, but as a good thing... with the Police... 'cause like, with some of these community Police Officers... if I see them up in Town, they always call me by my first name...' [Poppy: P:28. L:30].

Active Avoidance: 'Hide out in the library'

Participants protected themselves from abuse through active avoidance of situations or others. In childhood, this was achieved at home by escaping into books or schoolwork to avoid family. At school it involved actively avoiding other children by hiding in the library or changing time and route home. For example, Ella describes her deliberate intent to remove herself by detaching through schoolwork. This can also derive positive outcomes such as academic success and achievement.

'So I... in my childhood... I just focused... I read from an early age and I just focused on... reading books and escaping that way and doing lots of schoolwork...' [Ella: P:20. L:9].

This is also illustrated by Freddie.

'Family environment... really... it's just... Looking back at it... it's probably the reason that even back then, I always threw myself into school work and the like...because...I never felt like I had any kind of base... if you like... any kind of grounding and support... So, I'd throw myself into work, so I could say to myself, 'I've done well, I've got an 'A' in this'... or whatever...' [Freddie: P:8. L:12].

If possible, an alternative form of avoidance for some is to avoid home. William avoids his father.

'...when we were young we used to pray he'd be working Saturday morning so that he wasn't arguing or being around us... 'cause many a time I've been outside and it's raining in the garage... Because he was rowing with us.' [William: P:29. L:12].

For most participants, school was not a place of safety. The majority experienced bullying and abuse from other children. As a result, they employed tactics to actively avoid them through a kind of safety plan (Black et al. 2010). A number used safe environments and others, safe routes to and from school. The following extract from Amelia highlights the need to detach from others.

'But what I learnt quite quickly when I got out of junior school to junior high school... was where possible, just go and hide out in the library...you know, during break and what have you... You know, 'cause it was a bit of a safer environment...' [Amelia: P:34. L:1].

Freddie is forced to minimise opportunities for further trauma by changing his route home.

'Yeah probably from about ten as well... to avoid... so I didn't run into people along the way or on the way back...I'd take the long route round...and not walk the same way as everyone else did... 'cause I just wouldn't want to run into lots of people...' Freddie: P:19. L:1].

Others like Sophia stopped going to school altogether.

'...when it first started (bullying at school)... I didn't want to tell my parents... and the way I dealt with it was not to go to school... I used to bunk off school and not tell anyone...' [Sophia: P:44. L:31].

In adulthood, the process of avoidance is very similar to childhood. For instance, participants discussed avoiding people, including family, neighbours and so on. Ways of avoiding meant hiding at home, changing mode of transport, steering clear of certain localities, and even moving away from the area. For example, some that used schoolwork to escape in childhood could use university to escape in adulthood. Freddie acknowledges his motivation to escape the home environment was strong throughout his childhood and realised as an adult in university.

'I was up in [City redacted]... If you... to be honest, part of my... motivation for going there... was pretty much to get away... If that makes any... it probably sounds incredibly harsh... yeah, looking at it in hindsight, but that was... it was probably a big motivation... It's just... some kind of escape from the family that had... I'd always had...' [Freddie: P:11. L:19].

The option of university was not a reality for most. Therefore, other methods of escape and avoidance were necessary. Here, Isabelle details use of the local library.

'... so two days a week I started going to this day centre in [Town redacted]... the rest of the week I used to just wander around [City redacted]. I found sanctuary in the library, 'cause that was so quiet and peaceful...and I used to look at all the books on Britain and things... I've never been a big reader of books...' [Isabelle: P:12. L:28].

Participants also describe preference for avoiding the outside world or areas that are crowded or isolated. Ava provides an example of how she prefers to shut out the world.

'...I like it when it's dark... ha..and I'm in my house and I can draw all the curtains... that's the best time really... (Int: Mmm) I don't tend... I only go out in the car...' [Ava: P:22. L:3].

Others are more specific with the particular areas they avoid. This includes avoiding isolated areas such as the local park. Noah has experience of being confronted by local children in the park and so now avoids going.

'...I avoid going down (...) now and sitting there... (Int: Oh, so you avoid going down there now?) Yes... because of the school kids...' [Noah: P:26. L:4].

Alternatively, some avoid crowded areas.

'I don't go down Town very often now... and if I do go down Town, I know what I want and I know where I'm going... I'll get it and I'm out again...' [Jacob: P:29. L:26].

Environmental: 'Nice area'

The subordinate theme of environmental held a high level of importance across the sample. Security was not felt or mentioned within childhood and so all discussions are drawn from adulthood. Participants shared feelings on self-protection and their ability to influence this. The theme is interpreted in two subthemes of home security and neighbourhood.

Home Security: 'the door is sort of pretty hard to kick in': Participants spoke of home security on two levels. One is the importance of keeping property secure and second, having the means to do so. A range of options are discussed, including door and window security and living above the ground floor. What seems apparent is how home security equates to personal safety. With the majority of the sample living alone, personal safety is highly important. Here, Noah explains his security routine with a level of importance.

'So I've locked the windows... I shut them when I leave... open them when I come back... and keep my door locked... When I go down to the chute I don't leave my door open... I'm only down there for five minutes...' [Noah: P:8. L:20].

Others have a similar outlook but frame it in a different context. For instance, Poppy has based her security on the strength of the door.

'I feel pretty safe actually... You know, 'cause the door is sort of pretty hard to kick in...' [Poppy: P:37. L:8].

Living in a small block of flats is also cited by many as a secure environment. This is due to having an additional front door as described by Jacob.

'Well, I... feel a bit secure now, 'cause they put me in a one bedroom flat... it's sort of in a small block of flats... There's only about nine or ten flats there... and we got security doors... so people can't actually come and knock my door... unless someone lets them

in... So to a certain degree I do feel secure there... I mean, sometimes at night, I haven't even locked my front door...' [Jacob: P:32. L:24].

It is also an important security feature to be above ground level, as detailed by William.

'...I'm high up... I'm three up.... I mean I've got a security door... you know, you have to open with your own key...I'm three up and I've got good security.' [William: P:47. L:12].

Neighbourhood: In addition to home security, most participants mentioned their local neighbourhood. Appraisals were generally positive. This was surprising, given their ongoing experience of trauma and abuse as discussed in Chapter 10. However, good neighbourhoods were characterised by a lack of involvement with neighbours. Their level of anonymity improved the local environment and provided positive evidence of those around them. Other aspects of importance include the house feeling like a home and a general sense of living in a nice area. Here, Oscar shares positive thoughts on where he lives.

'It's a nice neighbourhood... It's a nice Town, a nice neighbourhood... Nice people live there...' [Oscar: P:23. L:28].

A similar appraisal is provided by Amelia.

'I mean I am not like one of these people who talks to all the neighbours... I keep myself to myself quite a bit... Errm, through past experiences like... but I've got names I can say hello, goodbye and pass the time of day... (Int: Mmm) But that's fine with me... I don't really want any further involvement...' [Amelia: P:4. L:26].

She continues.

'Even though the area is quite renowned for being quite a poor, run-down area... Errm, I actually feel quite safe there...' [Amelia: P:5. L:1].

For Poppy the environment is defined by a lack of influence from her neighbours. This provides a realistic gauge with which to measure the neighbourhood.

'...it's pretty quiet up there actually...I don't have no trouble from the neighbours...' [Poppy: P:6. L:32].

Evie has a new found anonymity that affords her some solace.

'...We moved and it felt quite good actually, 'cause I thought, 'Nobody knows me over here... I feel ok'' [Evie: P:15. L:11].

Not all shared such a positive outlook on their neighbourhood. Ava describes feeling stranded.

'Errm, I not... aghhh...ha ha (slight laugh).. It makes me sound like I'm moaning, but I hate living in [this city], errm, not just... It was the wrong thing to do... to move here... for me... (Int: Mmm) Errrm, and I'm finding it hard with my kids... moving on... as well, if I'm honest..' [Ava: P:25. L:9].

Superordinate Theme 2: Repressive Coping

This theme emerged as a strong representation of the sample. The theme is divided into four subordinate themes of ***Engage with Friends, Activity, Sensemaking*** and ***Self-enhancement***. All four are apparent across both childhood and adulthood, see Table (11.1). This theme considers how resilience forms part of the coping and adaptation process in the face of adversity. Closer examination reveals the use of repressive coping as an adaptive strategy to promote resilience (Coifman et al. 2007; Mauss et al. 2006). Essentially, this is achieved through a self-serving bias of perception that promotes coping and avoids emotion (Bonanno 2005; Weinberger 1990).

Engage with Friends: 'had a couple of really good friends'

Engaging with friends was mentioned by most participants through loose definition. There was limited closeness, regularity or continuity to their relationships with others. For example, participants described friends in childhood as others who did not bully them, sat next to them or were bullied themselves. Subjectively friendships are interpreted by participants as close, when objectively they appear not. However, this view may provide an adaptation to create normality. An example is provided here by Amelia, who engages with others in a similar vulnerable position.

'Yeah, well, yeah I mean infant and junior school it wasn't too bad. One of them [name redacted] was also overweight, so that helped... she got teased about her weight but I got teased about everything else...' [Amelia: P:33. L:10].

Others described friendships that were finite. For instance, Scarlett defines the length of time she had close friends. Having moved to a new school, Scarlett acquires two close friends. A

time-line is provided but no explanation of how or why the friendship ended. This was indicative of a number of participants, particularly when moving school or house.

'...But then, year... probably about half way through year seven 'til year nine... I had two very close friends...' [Scarlett: P:12. L:5].

Friendships were always transient in childhood across the sample. Here, Ava shares her experience.

'...I didn't have a lot of friends... I didn't... I moved when I was in infant school... so... I sort of had a couple of really good friends... and then I left them when we moved...' [Ava: P:18. L:26].

Ella adds her experience of friendship in childhood through the sharing of travel to and from school.

'...so there was a coach that used to pick people up...and I had a friend I'd sit next to on the coach. So all through my secondary school life... so she was a friend... but she was in another class... at school...' [Ella: P:27. L:34].

Others identified having friends but did not elaborate on the context, meaning or quality of the friendships. No names are mentioned or the basis for connection.

'Yeah... yeah, well, yeah, yeah I had friends yeah. Not too many... I had a few friends you know...' [William: P:37. L:5].

Poppy acknowledges the presence of many friends at school.

'...Oh I had loads of friends there... when I was at school... (Int: Mmm) Yeah, I used to have loads of friends at school...' [Poppy: P:20. L:3].

Isla was grieving the loss of her mother and move away from the family home in the context of her description of friendships.

'Errrr, it was hard to make friends... going from errm, living in town to living in a village, you know..? (Int: Right...) It was hard... but yeah, I made friends... you know..? I had friends in the class and people were nice outside of the other classroom...' [Isla: P:21. L:8].

In adulthood the participants appear to have access to more people as friends. As in childhood, it is apparent that friendships are drawn from those with similar challenges. For example, opportunities arise through mental health services, or accessing community groups. This establishes the normalcy of gaining friendships and being a friend, even if detached in the contact. In the following extract, Ella highlights her current support network.

'I mean now... what probably now, the main support is two or three close friends and... people at church... If, I was struggling with something it's mainly a friend I would ring or text...' [Ella: P:5. 15].

William identifies his social circle.

'...I've got a few friends now... but they're all like me... they're in the same boat...my friends are... they're all mentally ill...' [William: P:35. L:13].

Isabelle has a self-contained relationship with her husband and did not identify any friendships during the interview. However, she does remember the people present when marrying as friends.

'...We got married....with ten friends... that we found about in the pub...over at [Name Redacted]... Can't tell you the names of any of them really...' [Isabelle: P:15. L:7].

For those without friends or friendship groups, the local mental health charity provides a befriending service. This is invaluable support for some.

'I've got a floater (Befriender) who gets me out the house once a week...' [Jacob: P:17. L:19].

Ava details her engagements, including seeing a befriender.

'I don't go into Town and I don't really go anywhere other than here (drop-in)... and the [Psychotherapy Service]... errrm, errrm, I do meet my 'floating support' (Befriender) and have coffee at Sainsbury's. That's it.' [Ava: P:23. L:34].

Activity: 'Need to find a hobby...'

Having meaningful activity in life was an important aspect of coping and adaptation to trauma. Across the lifecourse, the majority of participants engaged in activity through hobbies.

However, they were generally lone pursuits that did not engage or include others. They described spending time alone walking, reading, computers, and handicrafts and so on. As a coping strategy their hobbies provide a distraction and occupation. For the majority, they do not provide connection, communication or community engagement. In childhood, very few mentioned activity for pleasure. However, some such as William and Scarlett did.

'I liked my childhood a lot... I used to do a lot of walking, cycling and walking and that... things like that...' [William: P:30. L:4].

William is describing time spent alone, whereas, Scarlett details time enjoyed with her Grandma.

'So, most days, and most days... practically all day when I wasn't at school or at friends, I was at my Grandma's. And we'd always be sat next to each other... and we'd be knitting together or cross-stitching, or... you know, making stuff...' [Scarlett: P:9. L:34].

In adulthood, participants report a range of activities. Only one participant is employed. The rest have no form of current employment and most have not worked for many years or never worked. Instead, activity involves attending local mental health charities, providing voluntary work or engaging in hobbies. For some, the drop-in service provides a place to be. Poppy explains her routine attendance.

'I just mainly come down here (drop-in) from day to day. 'Cause it's open like seven days a week and is even open on Christmas day and Boxing day as well... and I just like come here every day...' [Poppy: P:10. L:17].

Isla is insistent that the service has saved her life.

'If, if this place wasn't running (slightly animated). If I wasn't sent here...I don't think I'd be alive today. Ya know because they've been a lot of help to me here... and other people who comes... because they suffer with mental health...' [Isla: P:12. L:33].

Two participants highlight opportunities for voluntary work. This is provided by the local mental health charities as a serious form of occupation that enables social practise and engaging with others. Here, Ella explains her extensive engagements, highlighting the standing she holds within these organisations.

'...So I did a lot of voluntary work... I volunteer at [mental health charity]... I volunteer at the... [local centre]... I do a lot of work with the housing association... and do... some work with [two mental health charities]... So quite a lot of different organisations I... I volunteer at a residential home... so it's quite a lot of different organisations I'm involved with... two Sundays a month I'm involved in voluntary work with the church... One with a group of people with learning difficulties... another is an outreach...' [Ella: P:3. L:20].

The majority that mentioned activity described the pursuit of hobbies such as computers, knitting, handicrafts, reading and so on. Most are lone pursuits such as the solitary activities detailed by Freddie.

'So... yeah, currently building my fifth computer in a row, so... I have a bit of a geek tendency unfortunately... so... But no, I do quite a lot of reading... quite a lot of cinema... Like to just get out and about and... enjoy the countryside if you like... do lots of walking...' [Freddie: P:24. L:18].

Many of the female participants engage in handicrafts. For example, Scarlett finds solace in similar activities from her childhood.

'I've learnt to knit again... ha ha ha (laughed)... So... I'm knitting a jumper at the minute for my friend's baby... Errrm, I like watching films... (Int: Huh huh...) I play badminton occasionally... well, twice a week... Errrm... yeah, I like to read... (pause...)' [Scarlett: P:13. L:8].

Amelia divides her time between lone pursuits and activity with others.

'Yeah... I do a bit of handicrafts sort of knitting and that sort of thing... yeah, just...obviously do quite a bit on the computer... Spending time with my family and friends is quite important... Oh... that doesn't sound like a hobby but I actively seek out time to be with friends and family...' [Amelia: P:36. L:23].

Some participants describe needing encouragement to engage in activity for pleasure. Here, Ava explains her hobby.

'...I have just started making jewellery... earrings ha ha (laugh)... so... I saw [Doctor]... not this time but a previous time and he said I need to find a hobby... so...that suits me... if I get direction I'll do it. (laugh)...' [Ava: P:19. L:20].

On the other hand, most male participants did not mention activities or hobbies, which Oscar sums up in a blunt appraisal.

'Nothing (sigh...) I have no hobbies, no interests, no nothing...I've got nothing to do...'
[Oscar: P:16. L:32].

Sensemaking: 'She probably didn't mean any harm'

Sensemaking is interpreted as efforts to both comprehend experience and place rational meaning to it. The majority of the sample attempted to make sense of their experience in both childhood and adulthood. Such sensemaking can be a way of narrating child abuse experience in order to move from victim to survivor (Montalbino-Phelps 2004). In childhood, this is achieved by considering a range of external influences. They include fate (Crittenden 1996), inter-generational abuse (Lyons-Ruth and Block 1996, Valentino et al. 2012), parent as victim (Glaser 2002), culture of hidden abuse (Oates 1996), silence of abuse (Sanderson 2015) and being a personal target (Howe et al. 1999: 149). An example of the fatalistic perspective is described by Amelia when considering child sexual abuse.

'I think a lot is circumstance... You can't control who your family is... and I think that when bad things happen... it impacts your soul and it affects how you respond... and how you interact... I mean often... mental health... that has impact...from trauma as a child... I mean I don't know... and don't really understand... you know... how it alters your thinking and what have you...but, I suppose it has to...' [Amelia: P:39. L:23].

Ella makes a similar judgement based on fate and the inter-generational context of her experience.

'Because my grandparents... both sets of grandparents abused me... So...I was born into a family... that was very... steeped in abuse and it was still going on... and... that wasn't really anyone's fault whether I was born into that family...' [Ella: P:32. L:24].

Others made sense of their childhood through a perception of parent as victim. They expressed forgiveness in an attempt to understand their experience. This was evident in a number of accounts regarding the mother being fallible not the father. Here, Sophia provides an appraisal of her mother.

'...she probably didn't mean any harm with it, it was just the way she was...we were fed and clothed, well not loads of clothes and toys and that...we weren't rich...just a

working class background, but, you know... we always had good food on the table and she did her best... you know... it's just the way she is...the way things impacted on her... you know...in life...' [Sophia: P:36. L:5].

When describing peers who victimised there were only negative evaluations. No participant considered their actions as fallible, generational or understandable. Violence and abuse from school children was perceived as innate. Their victimising was seen as a personal choice. Here, Scarlett highlights a lack of identification with her peers. She shows no compulsion to understand. The sensemaking is her fixed perception of them.

'...But... the other people in my tutor group were just... Venomous... (said with meaning). Evil people... And... Well most of the school was to be honest...' [Scarlett: P:12. L:35].

Sensemaking in adulthood appears an attempt to reconcile traumatic events from childhood and understand current trauma. Some express forgiveness, empathy and understanding; whereas others focus on moving forward, attempting to recognise experience objectively. In the following extract, Oscar shares tenderness for the memory of his mother. He immortalises an image of how he wishes to remember her.

'...I've got a tattoo done of her... look (lifts his sleeve to reveal a tattoo the length of his forearm of a woman). So [...] I forgive her for what she did to me... Like to see my Mum? That's my Mum... an angel my Mum... (Int: So that's quite recent (tattoo)...) Yeah... I had it done a couple of days ago... My Mum was a beautiful lady... I forgive her what she did to me... I had a mixed up childhood...' [Oscar: P:6. L:31].

This also extends to trauma in adulthood. Some participants abused by parents or partners were forgiving in their attempt to make sense of their experience. For example, Poppy is accepting of her daughter remaining with her mother (grandmother) when asked to leave. She reflects on the circumstance with understanding.

'... Me and my Mum had like this big argument again and she said, 'there's no way that you're going to take your daughter'... you know, 'in case you have more fits...' I can understand it... her point of view. She was just thinking of the child and I still kept in contact with my daughter any way...' [Poppy: P:23. L:27].

James considers a traumatic relationship with measured acceptance.

'Yeah... It's the way it goes... You take the rough with the smooth within relationships... It's one of them... You either get on or you don't get on...' [James: P:23. L:28].

Evie makes sense of her abusive partnership through objectivity.

'...he was making me take these tablets... and... huh... in my own head I kept thinking, 'he, he, he's doing this for me' you know... he wants to help me and thinks the tablets are going to make me... better...' [Evie: P:20. L:11].

Self-Enhancement: 'I've kind of like re-invented myself'

Self-enhancement is a coping strategy participants employ to deal with their fears and difficulties independent of others (Sedikides et al. 2003). Although overwhelmed with much in their lives, they appear to demonstrate self-enhancement to compensate and restore control (Taylor and Armor 1996). In order to achieve this, some take responsibility, show tolerance of events, ability to persevere, proof of independence, and necessity for outward appearance of confidence to self-protect (Arkin 1981). This subordinate theme was evident in childhood, but mainly demonstrated in adulthood.

In childhood, self-enhancement is demonstrated as self-reliance in the face of abusive parents or peers. This resulted in some participants acknowledging their familial detachment or needing to portray stability at home or fitting in at school. In the following extract, Ava details her realisation of making a commitment to remove any reliance on family.

'...and then I was abused by my Dad and so, I think that's why I ended up being very... together... do you know what I mean..? On my own... and stuff... and not needing anyone... but also having to be responsible quite a lot of the time... or feeling I had to be responsible.' [Ava: P:12. L:5].

Instead of rejection, William holds the view that he was a favoured child.

'...my Dad liked me... well I was his fave... he didn't like my brother... He liked me better than my brother I think, my Dad.' [William: P:29. L:6].

With peers a dismissive regard for their negative influence was described by participants. Here, Scarlett summarises her thoughts on peers who victimised her.

'... it was just the way they treated you... and I just used to get on with it... I just used to keep my head down and get on with my work... And... I didn't care... about making friends, because I had friends...' [Scarlett: P:12. L:32].

Others reacted by attempting to improve their standing in school. For example, Amelia explains how she challenged her friend in order to influence her peers.

'Errm, and I remember turning on my best friend (Named redacted)... you know, but because I thought it would gain me some sort of recognition... yeah... it was horrible...' [Amelia: P:33. L:29].

In adulthood, evidence of self-enhancement is provided in comparable ways to childhood. Participants illustrate levels of self-reliance and ability to function in the face of adversity. In the following extract, Isla describes overcoming depression.

'It comes and goes but I'm the type who would try to fight it off. I'd have a good try and then I'd say to myself, 'get yourself together', you know it's only me who can do it... not my family... not the doctors. Nobody can do it... it's got to be me. (pause...)' [Isla: P:8. L:3].

Ava provides an indication of her ability to cope within an abusive relationship.

'I didn't have a particularly good relationship with [Husband]... errrm, so... but again, I've always been like a super-coper and so, you know...' [Ava: P:19. L:32].

Self-reliance is also demonstrated by Evie who describes a struggle for independence.

'You know, even though... financially, you know... it wasn't very good... and you know... two children as opposed to one... was very much different... I had my work cut out... But I refused any help from my parents or anything... I really wanted to do this... child on my own... I don't know... it was almost like I was trying to prove to everybody that I'm ok... It felt like I have got to be ok...' [Evie: P:16. L:31].

For Amelia, progress is identified in her ability to prevail.

'I would never have thought that I would be doing the stuff I do today... So I've kind of like re-invented myself... and left the negative... a lot of the negative stuff in the past really...' [Amelia: P:9. L:29].

Other participants appeared to magnify their influence or exaggerate difference. This seemed to provide an important context. Examples include Poppy and her perception of disagreements at home.

'Well I got on with my Mum sometimes, but if we got into a big argument... We got into a BIG argument (emphasis). And I always ended up winning it.' [Poppy: P:22. L:10].

Ella describes her supportive role.

'...very involved in the community with lots of different things... (Int: Mmm) and very... much able to speak on other people... to encourage other people and help their voice to be heard as well...' [Ella: P:28. L:30].

Scarlett enjoys an exaggerated negative vision of the school bullies and how their adult lives might turn out.

'...and I think about how these people (School children from past) are... They've got about twenty kids each and... they're just doing nothing. They're in council houses for the rest of their lives... They're never going to have a job, they'll have drug-dealing boyfriends... and it does make me think quite better about myself to think about them that way...' [Scarlett: P:13. L:28].

Superordinate Theme 3: Retaliation

Retaliation combines two subordinate themes of ***Against Self*** and ***Against Others***. Both themes were identified as a form of coping associated with the majority of participants across the lifecourse. Typically, they are immediate reactions to threat that involve turning on oneself or on the other.

Against Self: 'I just didn't want to carry on'

The manifestation of retaliation against self was dominated by suicidality, whether suicidal ideation, suicidal attempts or suicidal behaviour. Other aspects included not eating, giving up on life and giving up on self. In childhood this was apparent in two narratives. Here, Sophia describes a suicide attempt with indifference. No emotion is expressed.

'But the long and short of it is... that I attempted to take my life... you know... and I took tablets a few times... I was just very, very depressed... and... (Int: This is as a child..?) Yeah, well I was about fifteen...' [Sophia: P:3. L:23].

In another account, Amelia describes decline in her efforts at school. Amelia provides insight into her school record that was worn down by the experience of exhaustive victimisation.

'... I kind of like stopped achieving at school at that point... I mean my first couple of years at junior high... I did really, really well... I was in really high sets (streaming)... got really good exam results... but like the bullying just got to me and I kind of like gave in...because it took so much energy to get through each day...' [Amelia: P:35. L:4].

Evidence of retaliation against the self is mainly apparent in adulthood. The majority attempt suicide or express a will to die. All were nonchalant about the sense of gravity. Triggers included relationship breakdown, dismissive health professional, or being ignored. Others involved poor mental health and treatment. For example, responding to hallucinations, or feeling so paralysed by medication that death seemed the only option. Some events were planned and some were spontaneous reactions. Some acted on their ideation, others seem consumed by it.

The following extract details preparation by Amelia to take her own life. She appears to orchestrate events in order to be successful in her attempt.

'So, I kind of like planned my death (stated as a matter of fact, no emotion)... kids had been put into care... and I drew the curtains and people thought that I was away... and just started taking pills and drinking... and the next thing I know... I had woken up... a week later in intensive care...' [Amelia: P:18. L:11].

In a similar extract, Scarlett describes planning her death after failing at university.

'Errrm, I, that night... that errm, I'd been planning suicide for a while and that's kind of why I quit as well... 'cause I thought... if I withdrew, there'd still be stuff that my Dad would have to sort out. No, if errrm, if I'd had a leave of absence, there'd still be stuff for my Dad to sort out...with regards to uni. But that kind of withdrawing was sort of in my favour... I took an overdose and was in hospital for three days... and then I left the hospital that night and took another overdose the next day...' [Scarlett: P:6. L:15].

A number of participants described intrusive thoughts of death. They were mainly focused on not wanting to live. Sometimes, but not always, thoughts led to suicide attempts. An illustration is provided by Ella who shares a challenging period of her life.

'So.... probably from 2006 to 2011, I really struggled... and most of the time I wanted to be dead...after that major overdose I only took one slight overdose and then, I didn't... there was no self-harm after that at all...' [Ella: P:18. L:18].

William contemplates ending his life due to side-effects from medication.

'... I cycled all the way to [Name Redacted] Quarry... there was quick sand and sinking sand and a big weir about twenty foot running past... Well I was going to chuck myself in there... because if I've got to have that injection for life... I was that bad with that injection.' [William: P:44. L:26].

Ava found herself isolated after the children left home.

'Errrm, I just started to feel really suicidal Ha ha (laugh)... erm, I just didn't want to carry on...' [Ava: P:9. L:1].

Relationship breakdown impacted most participants. With the experience of rejection and sense of betrayal overpowering, some reacted against self. For example, Jacob is left in a void following the end of his relationship.

'...but eventually she (partner) just up sticks and went... trying time for me cause I didn't want to go on living, cause she was my life in a way... She kept me going... I didn't eat for three weeks.... A fortnight sorry...' [Jacob: P:8. L:18].

Isla is overwhelmed by a relationship breakdown where her husband left her in financial debt.

'Made us worse and I just had a nervous breakdown and... I just couldn't take any more. I just wanted to end it all... ya know?' [Isla: P:2. L:30].

Against Others: 'I can protect myself'

Retaliation against others was described by the majority of the sample across the lifespan. In childhood, participants retaliated against parents by ruminating about revenge, withholding emotion or responding in kind. There was some mention of retaliation against peers but this was minimal. In the following extract Ella describes thoughts of retaliation.

'Yeah, I used to... be awake late at night... thinking about burning the house down... to get rid of my parents... but I've no idea why I felt that way... and just blamed myself... It was actually, a lot of the memories that have come back... have been abuse of abuse from all the adult members of my family...' [Ella: P:19. L:33].

Some acted on their thoughts.

'I do remember deciding that I wasn't going to show my Mum that I wasn't... however hard she hurt me... I wasn't going to cry... you know... I wasn't going to show her... yeah, so it was just... it's more the unpredictability of it... In a sense it just happened...' [Ava: P:16. L:16].

Others reacted to provocation.

'I forgive her yeah. She didn't have me ... (emotional/crying) She died young... She (...) She can't say I was a baby all the time... 'How's the baby...? How's the baby...?' Shut up you fucking stupid bitch I used to say to her, 'I ain't got no fucking baby?...'*'* [Oscar: P:13. L:34].

Retaliation against peers was limited. In the following extract, Amelia describes attempts to belong within the bullying culture.

'Errrm, I remember doing things that were against what I felt was right... in order to try and... you know... be part of the click... I remember having this fight... with this other girl... And I don't even know why we were fighting, but I think, from thinking back... I think it was a sort of a bit of dare...' [Amelia: P:33. L:23].

On the other hand, Scarlett describes a rejection of such a culture.

'When I was sixteen, I set up an anti-bullying website and... it was quite a big thing... I was in the... on the national news...and on the regional news and in the papers and stuff. All because I'd set up this website, and... my Mum was really proud and everyone, you know, everyone who saw the website, I think like... I had emails off people from all over the place... who had seen it...' [Scarlett: P:16. L:22].

In adulthood the narrative was split between actual retaliation and intent. Actual retaliation was presented as violence, self-defence and crime. Intent included self-protection such as practising martial arts, carrying or sleeping with a weapon. The first extract illustrates violence in the home. Noah alludes to the violence being linked to poor mental health. He does not elaborate any further on the circumstances.

'Oh well I used to hit him one (brother)... (Int: You used to hit him one?) Yeah... and I used to hit my Mum... That's why they had me put on a section (Mental Health Act)...' [Noah: P:19. L:23].

Some defend themselves against others through a show of aggression. For example, William described standing up to bullies.

'...these two Asian lads about nineteen and twenty went WWHAAAAHH!!!... like that as I went past... and I didn't say anything I just walked on. I went on... about twenty or thirty feet to the fitness centre... it's closed upstairs and now there's a plaque up outside... and I just turned around and they were shouting at me... so I put my fingers up and one of them took his belt off to me... well the other one picked up the plaque first as if to run at me and chuck it at me... and the other one ran down and took his belt off... and I had my D-lock in my hand, 'cause I had my bike... and I said, 'come on then' and he backed off the one did... and I called him a wanker... wankers I said to them... Ikedo. (Int: Ikea..?) No I said Ikedo... you know like Bin Laden's Ikedo... (Al Queda) that's what I said to them' [William: P:43. L:18].

Another facet described by one participant is committing crime. Here, Freddie presents the context as to why he stole from his employer.

'I was... basically emotionally blackmailed... To... basically to take money from where I was working to help her (fiancé) financially... and of course, like a fool I agreed. I don't know... I just didn't have any kind of... at the time... any kind of... self confidence at the time... to just say 'No'... And she knew that... she could see that... (Int: So when you say, 'take money from work') Huh huh... (Int: What do you mean?) I mean theft...' [Freddie: P:27. L:12].

Retaliation against others incorporated the intention to self-protect through force if necessary. This included skills in martial arts or use of a weapon. Poppy provides an illustration of her sense of strength in self-defence.

'... 'cause a few years back... I used to do Judo quite a lot... And I've got quite a strong punch on me as well... when I want to. (Cough)... (Int: So you feel that you can protect yourself?) Yeah, I can protect myself when I want to.' [Poppy: P:30. L:7].

Others feel access to a weapon is necessary. Here James explains initially through humour and then with seriousness, how he would defend himself.

'(Int: So what do you do to protect yourself?) What do you mean? Where I live? (Int: Mmm) I've a double-barrelled shotgun... That's a joke, that's a joke... Not laughing... I

sleep with a carving knife under my pillow... If someone broke in, what would I do? Stab 'em...' [James: P:27. L;19].

In a similar extract, Oscar is hesitant to share how he protects himself.

'(Int: How do you protect yourself now....?) What, you want to know do you? You're not going to tell no-one..?' (he stands up and produces a stanley knife from his pocket to show me... I do not feel threatened)... But I'm only going to use it if they hit me first...' [Oscar: P:22. L:6].

Summary

Reactions to the immediacy of trauma are manifest in ways of coping and adaptation that promote survival and self-protection. Narratives describe a range of strategies to navigate traumatic experience. Some provide personal safety, whilst others provide distraction from reality. A number are successful in shielding the participant, but a significant amount only serve to add further tension or trauma. Importance is given to making sense of experience which often leads to self-denial or false perception of support. Some cope by turning their anguish on themselves, some by turning against others. Ultimately, by reacting to actual harm and potential threat the participant survives. Whilst this enables immediate progression it does not mitigate longer-term impact, the major theme discussed in the next chapter.

Chapter 12

The Impact of Childhood Trauma

The third master theme to emerge from the findings is **The Impact of Childhood Trauma**. The previous chapter identified how participants cope and adapt in order to self-protect and survive. This chapter provides a comprehensive overview of the pervasive way trauma impacts their lives. Such impact is profound and far-reaching in a way that overwhelms the participant. In the face of adversity, their struggle is worsened by a breakdown of personal and social connection.

Three superordinate themes were identified, including *Distorted Perception*, *Segregation* and *Poverty of Well Being*. They are presented in Table 12.1 with their subordinate themes. The key provides a visual overview illustrating impact experienced in childhood, adulthood or both. Some themes are specific to age and circumstance. For example, '*Vulnerability to Others*' was described by participants in adulthood only.

Table 12.1: Cross Case Identification of Recurrent Themes: The Impact of Childhood Trauma

Themes			Participants															Present in over half of the sample	
Master Theme	Superordinate Theme	Subordinate Themes	I	J	A	A	P	O	S	W	J	N	E	E	S	I	F		
			s	a	m	v	o	s	o	i	a	a	o	v	c	s	r	e	
			l	c	e	a	p	c	p	l	m	h	l	a	r	a	b	e	
			a	o	i		p	a	i	e		e	r	e	l	e			
				b	a		y	r	i	a	s				t				
The Impact of Childhood Trauma	Distorted Perception	Negative Self	X	X		O		X		O			O	v			X	Yes	
		Vulnerability to others	O		O	O			O	O	O	O		O	v	O	X	Yes	
	Segregation	Isolation:	X	X	v	X	O		X		O	O	O	v		v	X	Yes	
		Lack of Close Relationships			X	X			X	O	O	O		v		X	X	Yes	
		Limited Education	X	v		v	v	v	v	v	v		v		O	X	X	O	Yes
	Poverty of Well Being	Physical health	X	X	X	O	O	O	O		O	O	O	O	X				Yes
		Emotional health:	X	X	v	O			X	X	X			O	X	O	O	X	Yes
		Mental health	X	O	O	O	O	O	X	O	O	O	O	O	X	O	X		Yes

Key:
v = Childhood,
O = Adulthood,
X = Both child and adulthood

Superordinate Theme 1: Distorted Perception

Impact of **Distorted Perception** was evident in the majority of the sample. The theme presents two subordinate themes. One is **Negative Self** and the other is **Vulnerability to Others**. Both appear to alter perception of the self and others as a result of trauma. Some reflect on childhood experience, but the majority identify an impact in adulthood. They describe a pessimistic self-view and being susceptible to exploitation.

Negative Self: ‘I don’t think a lot of myself’

Negative self featured in over half of the sample. Participants perceived themselves as having a negative influence on life events, lacking any worth, and lacking a future. Accounts were drawn from across the lifecourse. In childhood, participants were self-deprecating or expressed negativity through self-blame. In the following extract Oscar provides a very direct negative

appraisal of his school ability and essentially his derogatory self-view. His use of language reiterates his point.

*'(Int: How did you get on at school?) Shit! I'm as thick as shit... I'm as thick as shit me...'
[Oscar: P:15. L:24].*

Participants who experienced loss at an early age expressed self-blame for the outcome of events. Here, Isla offers an emotional insight.

*'...I didn't seem to see much of my Mom as much as I had wanted to... Even in the hospital... I had to go away and leave you... You know? and that's... plays on peoples minds at that age... and then when they die... You don't know... you just think of everything about... Was it something I'd done... you know, was I naughty... you know you just... Nobody knows you know, not even now...'
[Isla: P:23. L:20].*

A similar account of self-blame is provided by Jacob.

*'...I was pestering to go and see a film... And she kept saying, 'no... no'... and I suppose I kept on at her... and I went home and I sat on the step... sulking and that... She came out with the washing and I said, 'look Mom... can I go?' and she blew her top at me... She didn't actually swear but she said, 'go then if you wanna go'... Cause I got me own money and everything and of course I went... and about three or four weeks later she was taken into hospital... And I suppose to a certain degree, I blame myself for it... it's as if I was getting on to her all the time... and made her feel worse sort of thing...'
[Jacob: P:20. L:9].*

Self-blame is also evident in other accounts. For instance, some participants described turning negative feelings on their self. Here, Ella talks about her experience within an abusive family.

*'...I wasn't... really given any opportunities to ask for help, or if I should ask for help, or you know, who to ask... I just blamed myself... 'cause I had all these negative feelings towards my parents...'
[Ella: P:20. L:26].*

Another perspective of blame is portrayed by Freddie, who believes he negatively influenced the perception of others for being different.

*'And of course, you go to school or anything like that... You mark yourself out as something a bit different...I suppose you just paint yourself as a target don't you?'
[Freddie: P:18. L:15].*

Later in the interview Freddie expresses guilt and blame for trauma in his childhood home.

'Just... for so long I had this feeling of... of guilt. It's my fault... I should have done more... I should be able to help more... (Int: Mmm) And... especially during those years... before I got help...' [Freddie: P:29. L:9].

There is evidence of negative self in adulthood across the sample. Participants describe a self-loathing, self-degrading, self-critical view and lack of self-belief. Their negative self was portrayed as a defeated self. In this extract, Jacob provides a blunt appraisal.

'Because I suppose in a way... I am a coward. I do run away from things...' [Jacob: P:35. L:30].

Oscar shares his confusion for his identity and describes himself through anger.

'It's not right in your life... Sometimes I don't feel I'm a human being... more like a piece of shit or a piece of meat... or a piece of steel. I don't know what the fuck I am.' [Oscar: P:19. L:16].

Others feel their negative identity is forced upon them from others. For example, William shows negative regard for his own status, using language that demeans his value and contribution.

'It's just, just... doesn't matter what I believe anyway... I suppose I'm crazy anyway, so it doesn't matter does it?' [William: P:52. L:23].

Such defeat to a negative self is also evident in the following brief account from Ava.

'Yeah... I don't think a lot of myself... so... I think basically that's well, you know... it doesn't really matter how someone treats me...' [Ava: P:20. L:7].

Such distorted perception impacts self-view, world-view and view of the future.

'... yeah... yeah... I sort of live day to day really I suppose... I don't really see... I don't really see a future beyond the next... I don't know... few hours or whatever... I don't feel I've got anything... (pause...)' [Ava: P:24. L:32].

A similar expression is provided by Isla, who reiterates her feelings by stating them twice.

'... got no future now have I..? Nothing... no work... because of this (pointing to leg and arm)... I don't have a future...' [Isla: P:28. L:5].

Vulnerability to Others: 'People will pick on you more'

Vulnerability to others was mainly expressed in adulthood. It was detailed as a visible vulnerability to a supremacy others hold over them. Such power, whether perceived or actual, is experienced through shame, hurt and rejection. In addition, some feel their position in society is determined by others. This in turn increases fear or resentment, leaving participants distressed, paranoid and marginalised. In the first extract, Scarlett is angered by her childhood experience of victimisation going unpunished and continuing to impact.

'I have been thinking about the stuff that happened at school. I've been thinking about it a lot recently... and... it still makes me quite mad... (Int: Mmm) ...to think they did that and they got away with it...(Int: Mmm) So it does, even now and this is ten years down the line... since it started, and I still think about it... (Int: Mmm) Errrm, so that... it does... I think it does affect my quality of life...' [Scarlett: P:18. L:22].

On the other hand, Freddie believes victims can invite victimisation, by presenting self as different.

'But now... but now I don't know... I think, how you... hold yourself outwardly... can invite... this... victimisation... this outward attention... if you like... I think it can have a big influence on it...' [Freddie: P:32. L:19].

In adulthood, a range of incidents were presented by participants with regards to their sense of vulnerability to others. This involved others as outside family, such as health professionals and often unknown peers or neighbours. William details an encounter with his GP.

'Do you know what she said to me the next time I seen her..? "Why don't you get a job?" (said menacingly)... She said it like that... and I said, "There's mass unemployment at the moment and I wouldn't handle the stress... and the only job that I would get is what a refugee don't want." I'm labelled paranoid schizophrenia... How does she expect me to get a job..?' [William: P:9. L:30].

Here, Sophia shares her thoughts on the visible vulnerability she believes others prey on.

'I think people will pick on you more as well, when they see that you've got... when they know you're a bit vulnerable, you know... when you're a bit... you don't feel so confident... you tend to get more trouble off people...' [Sophia: P:27. L:18].

She later provides further analysis of being targeted at the drop-in centre.

'Because they think, oh well I can get away with it with them... they're not going to you know, like, say anything or they're the last person in the door and... a bit isolated and want to make friends and haven't got anyone to back them up... they tend to like, you know... zoom in on you, if you know what I mean..? I think that's why I've had a lot of trouble off people in the past...Yeah...' [Sophia: P:27. L:25].

To deal with such vulnerability, some adopt a passive self or withdraw. Their perception of others leaves them vulnerable and fearful. Here, Ava details her attempts to placate.

'...I try to please everybody... so... I try to make sure I don't get... you know..? So... so I suppose I am very unsure of people... full stop really... (Int: So how do you deal with that?) How do I do..? (Int: How do you deal with that? Being unsure of people...) At the moment... hide... Ha ha (laugh)... but... I always want to make people happy... do you know... Please them. I think if I keep them happy then I'll be okay... so... yeah.' [Ava: P:21. L20].

Following a previous altercation Isla has a fear of her neighbour that impacts her mobility.

'...since that lady has moved in I'm getting so I won't go out and... Unless, her car is away then I'll go out to my bin or put my washing on the line. (Int: Oh ok. You wait... for her to not be in?) Yeah, I wait until she's not in because I am so scared of her. Ya know? ...But errmm, she's a scary person (huh!)...' [Isla: P:7 L:13].

In a similar extract, Amelia is fearful of her previous neighbour who victimised her about mental health problems.

'...I'd had a couple of bouts of in-house treatments at the hospital. So it was fairly well known that I'd got problems... and I think she, kind of like, saw that as a weakness... and also, I'm not the sort of person to fight back... or I wasn't.' [Amelia: P:14. L:21].

Superordinate Theme 2: Segregation

The superordinate theme of **Segregation** is identified as incorporating three subordinate themes; that of **Isolation**, **Lack of Close Relationships** and **Limited Education**. Participants describe a range of difficulties with the social world. Their lived experience of childhood trauma and unsuccessful coping strategies leads to lifelong impact of segregation. They are marginalised in terms of intimate or social connections and lack closeness in any form of

relationship. Also, the majority are further segregated by poor educational attainment that impacts their everyday communication and ability to progress.

Isolation: 'I just kept to myself'

The impact of trauma leaves participants isolated from the social world. Some experienced it in childhood, others adulthood and a number described isolation across their lifecourse. Descriptions included circumstantial limitation, withdrawal and loneliness. In childhood, withdrawal is often through choice, but sometimes due to external influence such as moving home. They become loners at school, not involved in school life or their social world around them. This was mainly due to a lack of social competence, lack of inner confidence and rejection from others. Examples are presented to highlight the participant struggle with the social world. Here, Ava explains the impact on her.

'...I just kept to myself really, it was... especially once I became a teenager... I went and did my... I went to school...you know... did anything else and just kept... to myself really...' [Ava: P:14. L:32].

Isabelle is describing her time at school.

'I was very much a loner... Very much did things on my own...' [Isabelle: P:39. L:6].

Jacob reiterates with a definitive statement of isolation since childhood.

'I have always been a solitary person...' [Jacob: P:11. L:9].

In the following extracts, participants attempt to understand their isolation at school. Here, Ella describes an inability to form connections. Many experienced comparable situations where a lack of social competence is evident in their narrative.

'I didn't really have any friends...I wasn't really encouraged to... and... I was very introvert...and didn't really say very much...and... during secondary school I had a few friends but, not very long. So, it was mainly a lot of time on my own...' [Ella: P:27. L:27].

Freddie recalls his experience of marginalisation at school with clarity and emotion.

'...I know kids are kids...and can be pretty cruel sometimes... but sometimes they go over the border and it becomes very difficult to deal with... especially when you haven't got... any kind of support network really...' [Freddie: P:17. L:21].

Later, he goes on to describe the impact further.

'I would... keep myself to myself in the break times and the like outside of class lessons... and I found it very difficult for... social groups and friends and the likes... (Int: Mmm) I'd usually be found in the library working...' [Freddie: P:18. L:18].

In adulthood, isolation seemed to centre on the loneliness of being alone and the lack of support. As adults, participants have become more withdrawn. They spend more time on their own. The only opportunity to meet others is through mental health groups and spending time with others in the same situation. Sophia explains.

'...it's this pattern that keeps repeating... I don't know... I think through loneliness I get involved with the wrong people... or something... I'm just glad for people to be my friends and maybe they're not suitable people to be my friends but you're kind of limited when you're not working... You just go to mental health places and... You know... it's kind of a bit difficult... working out people... and who to trust and who not to trust... and sort of dealing with things in isolation... on your own ...' [Sophia: P:30. L:24].

Most participants are unable to trust the intentions of others or the uncertain social environments they attend. This is reiterated by Ava.

'I can you know... think well I need to like...do more sort of socially so I'll go to an evening class or whatever...do it for two weeks and get convinced that nobody likes me...or whatever... and I've always been a bit like that anyway...so... So, yeah, no I'm quite on my own...yeah... yeah. (seemingly sad).' [Ava: P:19. L:17].

Some participants discussed their isolation in terms of social collapse or complete withdrawal. This may be due to a relationship breakdown or a period of distress. Freddie talks of his experience.

'... 'cause when I split up with old fiancé five years ago, we also had lots of mutual friends... And when that went, quite a lot of that fell through as well... It was just very difficult... So after that time I became really ill... Then socially... lots of things fell through and I became very isolated...' [Freddie: P:23. L:14].

Evie connects a period of distress with her withdrawal.

'...Huh... it was hard for me to get out of the house.... I remember we went through a period... I suppose I was isolated...I remember staying on this settee and I thought... I don't want to get off it... I was really, really, really scared...' [Evie: P:29. L:21].

The majority experience lifelong isolation. This is summed up by Isla. She provides an honest appraisal of her feelings since childhood to her current loneliness.

'...it just seems like from the time I was young I've been on me own really. Taken away from my brother and my five... four, sisters sorry... and then all this... me with my husband going off too, just on me own again, aren't I? It's just... See this is how it hits you. You just go back and it's like when you were younger, your Mum left you. You're on your own... nobody is about and everything just goes around in your head... You feel lonely... I hate night times... I can't sleep. I am lucky if I get two hours...' [Isla: P:18. L:9].

Loneliness at night is what Noah feels is his worst time.

'(Int: What's been the worst time for you?) (long pause...) I get lonely at night...' [Noah: P:16. L:16].

Lack of Close Relationships: 'I didn't really have any friends'

Lack of close relationships was identified across the lifecourse. In childhood, the majority had no close relationship with family members and so the focus is on friendship. Participants talked of not having friends, not having the necessary skills to make friends and being rejected by peers. This was often described as a result of house or school moves or long periods in hospital. Such upheaval and changing social environment was detrimental to the formation, maintenance and dissolution of close relationships (Hazan and Shaver 1994). Here Isla discusses her experience.

'... It was hard to make friends... because I had no friends... did I... when I was younger... being in hospital... and then having to go and live with my Auntie.' [Isla: P:17. L:32].

This was similar with Ava who moved home.

'...I didn't have a lot of friends... I didn't... I moved errrm, when I was in infant school... errr, so... errrm, I sort of had a couple of really good friends...errrm and then I left them when we moved to [City Name Redacted]... when I was twelve... and so I started all over again.' [Ava: P:18. L:25].

Others, such as Oscar, believe their inability to make friends is based on moving school.

'I couldn't make friends 'cause I went to two different schools... a Protestant and a Catholic school... and I was just mixed up... terribly mixed up.' [Oscar: P:6. L:6].

Freddie also moved schools, which impacted his ability to form friendships.

'(Int: So during middle school, you went to two different middle schools?) Yes, as far as I... Yeah... errrm, and two different comprehensives as well... (Int: Ok... but they were still in the local area?) Yeah. (Int: And you're not sure why that was...?) To be honest, I can't remember being consulted or anything... ha ha... (Int: Huh huh...) Aghhhhh (sigh)... (Int: And what about friends at school?) Difficult...Really quite difficult to be honest... I just... I find it a lot easier to talk and be social now than I did then... (Int: Mmm... Mmm...) And if you like, I'm just being the academic figure of fun if you like...it made pherrrrr, it made making friends really quite difficult...' [Freddie: P:20. L:9].

Rejection from peers is also a feature of a number of accounts. In the following extract, Amelia describes her transient friendship.

'...yeah, I mean the one friend was great because often, you know, 'cause of lack of money and whatever...we were sent to school without a lunch or anything... and she (friend) would make sure that, you know... she had something extra... but, when she was with her kind of like, group of friends, they didn't want me around, so...I was isolated at times...' [Amelia: P:33. L:19].

This is shared by others.

'(Int: So did you have friends at school?) Very few... I was very much a loner... very much did things on my own... (Int: And how was that received by the other kids, the other children, the other girls?) Some just wouldn't bother to talk to me anyway... (spoken quietly). I didn't... I don't... make friends easily... I never have done...' [Isabelle: P:39. L:6].

One participant suffered from asthma as a child. As a result, teachers kept him inside during break. Although protective, it was isolating.

'They decided that come playtime I can sit in a classroom instead and study... (Int: Mmm) Which... Hah! (Exasperated) I didn't like... (Int: Mmm) You know... It meant that I didn't get, errr, to play with or meet friends sort of thing...' [Jacob: P:11. L:4].

In adulthood accounts describe a lack of connection with others. Relationships are generally detached or non-existent. This includes family, peers or partners. Any partnerships discussed have been abusive or traumatic, as identified in Chapter 10. But for the exception of one participant who is married, none of the sample is currently in a relationship. Close friends and confidants are described from a detached position. Their close friends do not appear objectively close, but accessed via telephone, social media or letter, rather than face-to-face. Some live in other cities or even other countries. There was rarely a mention of social events, engagements, meetings or gatherings with friends, or names of friends by any participant.

In the following extract, Sophia explains how rejection has impacted her life.

'...I've had a lot of rejection, you know... off people... over the years... And that hasn't really helped, you know... my confidence... it hasn't helped... I haven't really managed to... form close relationships... you know, with people and people I can rely on...' [Sophia: P:19. L:31].

Noah also describes rejection from his one friend ceasing contact.

'[Friend] used to come here... He used to come on a Saturday to see me. He used to phone me at eight o' clock... He stopped that now... 'cause I shouted at him on the phone... So he stopped that now...' [Noah: P:16. L:19].

Ava believes that not being local impacts on having any friends.

'Errm, I spend a lot of time on my own.. Errrm, I don't come from [the City]... So... I haven't... really... sort of got errrm, a network of friends really...' [Ava: P:6. L:21].

Later in the interview she adds a succinct summary.

'I don't trust anybody... I think that is the problem with me...' [Ava: P:24. L:6].

Other relationships discussed in adulthood included siblings and participants own children. For example, sibling relationships are poor or estranged. Reasons included being lower in family

hierarchy, reminder of abusive past, or resemblance to abusive parent. Here, Freddie expresses experience of his brother. He has a shared history and sibling connection but no close relationship.

'... I find him (brother) more difficult. To be honest, I always did. I just... at the risk of sounding really, really harsh... there's always a bit of him that reminds me of my father... Just the habits, the mannerisms, the... Sometimes, the blind refusal to see anyone else's point of view... and yeah, I do feel really harsh saying that right now... And I think that's why I still find him really difficult to deal with until this day...'
[Freddie: P:14. L:17].

Lack of close relationship was also identified as intergenerational. Participants explained their estrangement from their children.

'...my eldest son... he'd spent most of his... Well from the age of about nine or ten, he'd lived in Foster Care... our relationship was very complex... and I was taken seriously ill... Which meant we were separated... and we just... he was so damaged by that separation because he never had any real time away from me before... I was in hospital, for medical reasons... for four months... and when we tried to, kind of like, bring the family back together... he just couldn't cope... So he spent quite a lot of time in Foster Care...' [Amelia: P:11. L:20].

Sophia talks about her son leaving home to live with his father and not keeping in contact. The relationship drifted and remains estranged.

'...I'd been the sole carer with not much input from his father... and... to... no longer having my son there... (Int: Mmm) ...and that was devastating in itself... Errrm, I tried to keep in contact with him as best I could...' [Sophia: P:58. L:4].

Limited Education: 'I couldn't read or write properly'

Childhood trauma is associated with long-term deficits in educational achievement (Gilbert et al. 2009). This was the experience of the majority of the sample. Accounts are mainly situated in childhood due to compulsory school attendance. What is evident is that on leaving school most participants had no qualifications. They shared an overwhelming dislike of school to the point of hatred. The main reason expressed was victimisation from students and/or teachers. Some participants were removed from mainstream education to attend 'special school' for students with learning difficulties. A small number did have the opportunity to attend university, but the majority were left with limited educational attainment. They are further

marginalised by the experience and left with long-term consequences of limited economic opportunity (Currie and Widom 2010).

A number of participants blamed their schooling for poor academic attainment. Here, Oscar feels he did not receive an adequate education in preparation for adulthood.

'I couldn't read or write properly... 'cause all I was taught was bullshit at school and all I wanted was how to read and write properly... and go off and fight and die for Queen and Country...' [Oscar: P:4. L:7].

Poppy shares a similar overview of a lack of education in 'special school' for learning difficulties.

'Well (cough) because... because it was like at special school... I didn't have to take any qualifications... anyway... Because, like I said... 'cause it's one of these schools for the people that were mentally backward anyway... I didn't have to do any exams, you see.' [Poppy: P:26. L:20].

A similar sentiment is conveyed by Noah who talks of his secondary school.

'...It's a special school...for backward people... (Int: In what way backward..?) Can't write a letter... can't fill forms in...' [Noah: P:24. L:9].

Others blamed their own lack of ability. Here, William offers his thoughts.

'I mean errr, I wasn't very good at school. Instead of French they gave me extra English lessons...'cause trying to improve my English... Err, at Junior School. I wasn't very good at English... I'm the black sheep of the family... my sister and brother were better than me at school... I wasn't academically inclined...' [William: P:35. L:1].

Ava also provides an appraisal.

'I struggled... sort of... academically... but I was quite into sport...' [Ava: P:17. L:1].

Isabelle felt forced to fail academically in order to please her father.

'...when I took my mocks, I failed... English... and my Father stamped his feet and said, 'No daughter of mine is ever coming out of school without English O 'level'. So, I threw

all my other books in the bottom drawer, didn't look at them all. I failed science, I failed maths, I failed physics... (Int: Mmm) Which I was good at... I was getting B's and nearly A's in that... (Int: Huh huh...) But I failed them all...' [Isabelle: P:3 L:7].

Other participants experienced an educational disconnect as a result of long periods in hospital. Jacob spent months at a time for asthma.

'We did do some schooling while I was there, but not to the extent that you got eight hours a day sort of thing... (Int: Mmm) We'd probably have a couple of hours in the morning and that was it...' [Jacob: P:10. L:13].

Isla spent years out of school due to an accidental head injury.

'Errm, started school... when I was five and then... in the November I got hit [Accidental head injury] which... I didn't get back to school until I was ten... Because I had a lot of problems with hearing and speech and...' [Isla: P:20. L:3].

Indeed, Sophia spent time in hospital for mental health problems and also removed herself from school by playing truant.

'I didn't have any education while I was there [hospital]...They made me go back to school... you know... After having all that time out, I had to go back to take a couple of exams... (Int: How much time had you had out?) Well... I'd been in and out of school for about two years... you know... like, I think it was about two years I'd been truant. Nearly two years on and off...you know, playing truant and...' [Sophia: P:4. L:20].

Some attended school but expressed vehement opposition to students and teachers; related to their experience of victimisation. Here, Scarlett provides a forceful extract that reveals continued impact.

'No. I hated school. I haven't got a nice memory of school and I wouldn't go back there if someone paid me to go back... (pause)... (Int: Why is that?) It was just horrible. I absolutely hated school. I hated the teachers and I hated the other students.' [Scarlett: P:12. L:16].

The theme of limited education was not mentioned by many in adulthood. However, it was identified in the continued struggle with reading and writing, failing exams and withdrawing from university for the participants who had been successful at school to gain a place. It was

evident that such issues stemmed from childhood experience. For example, Isla continues to struggle.

'I'm not very good now... sometimes with reading or spelling...' [Isla: P:20. L:14].

Isabelle entered nurse training at a local hospital but was unable to complete.

'...I started off doing the RGN training... (Int: Mmm) General... Err, after the first year I failed the exams... the theory exams... but... I came out tops on all my ward reports... and all my projects... (Int: Mmm) I done... So they filed me into the Enrolled Nurse...' [Isabelle: P:5. L:36].

It also applies to participants who had success at school and attended university. In the following extract, Scarlett recalls how depression impacted on engaging and completing her university nursing course.

'It made uni practically impossible. It took me two years to do my first year... and then, I started my second year and my first term fine... and then my second term I went to a placement for a day... then I didn't go back again...' [Scarlett: P:4. L:31].

Freddie had to withdraw from his university course.

'Oh... (exhale) pretty much all the way to be honest... I did... I went through to A 'levels at eighteen. After that I... I went to university at eighteen, but had to withdraw, for... various reasons... and returned to it in later life...' [Freddie: P:2. L:29].

Ella had a similar experience.

'...I got A levels... I went on to [university] to study but had a breakdown...' [Ella: P:2. L:21]..... 'Int: How far did you get on your course? I only did six months.' [Ella: P:2. L:29].

Superordinate Theme 3: Poverty of Well-Being

The superordinate theme of **Poverty of Well Being** was identified by the majority of the sample. It incorporates three subordinate themes of **Physical Health**, **Emotional Health** and **Mental Health**. Attempts to overcome childhood trauma, coupled with the negative influence of insecure attachment style take their toll on participants. Poor coping strategies and the impact of lifelong marginalisation ultimately lead to a breakdown in health and well-being. This

is consistent with research exploring childhood trauma and increased risk of physical health problems (Goodwin and Stein 2004; Spertus et al. 2003); emotional health problems (Glaser et al. 2006); and mental health problems (Perales et al. 2013; Chen et al. 2010).

Physical Health: 'I'm very much ruled by my condition'

Physical health problems were apparent across the sample. The majority experienced significant physical health problems, some across the lifecourse and others adulthood only. In childhood, physical problems were described by some individuals. Conditions such as asthma and epilepsy were mentioned. Two participants described long periods in hospital. This removed them from their family and influenced their long-term well-being. Jacob was one.

'I've been asthmatic since I was four years old. I had a collapsed lung.... (pause) And I had two times when I went to [Name Redacted] hospital... I think it's an 'old people's home' now... One when I was about eight and second time when I was about ten... and they were about three or four months at a time.' [Jacob: P: 1. L:10].

Another example is provided by Isla who suffered a severe injury to her ear and neck during childhood that impacted her very survival.

'I wasn't well being in and out of hospital. It's hard for a nine year old being stuck in hospital... not seeing her Mom. And when I got out I got a lot of infections... It was touch and go loads of times...' [Isla: P:16. L;28].

For others, a visible physical ailment was the source of further ridicule. Here, Amelia explains her experience of being overweight and suffering a skin condition.

'I mean I was overweight as a child as well... so... I was the butt of every joke... and I had this condition with my ears... where my ears just bled all of the time... so I was just, it just all kind of like...added to... reasons why I should be bullied...' [Amelia: P:32. L:27].

In adulthood, the main physical difficulties described appear linked to somatoform syndrome, including irritable bowel syndrome (IBS), persistent pain, migraine and fibromyalgia (Wessely and White 2004; Halland et al. 2014). Each condition impacts the lived experience of participants. Here, Amelia explains her difficulties.

'I let things go at the weekend if I need to... but again, that just depends on how my fibromyalgia is... so... It rules my life... which I don't like... (Int: And how does that rule

your life?) *Well (clearing throat)... don't have a day symptom free ever...* [Amelia: P:6. L:14].

Ella makes a connection between her physical health and traumatic childhood.

'My main problem is I've got fibromyalgia... as a result of years... trauma as a child... but... (Int: Sorry, what's that?) Fibromyalgia... which is an illness... pain in every muscle and exhaustion... So my main problem really is the pain and disability...' [Ella: P:4. L:21].

Other conditions such as migraine and irritable bowel syndrome have the same impact. Isla gives an account of how debilitating her physical problems are.

'It's a condition called [...] Migraine (Possibly Hemiplegic Migraine). I get a pain in my head and it comes all down my left side and you'd think I was having a stroke, but it's not. It's the same symptoms but I come out of it, thank God... But it can last for a long time. It could last for a short time...' [Isla: P:9. L:33].

For Sophia, her condition is all-consuming.

'(Int: So you said you have IBS?) Yeah... (Int: And... how does that affect you or to what degree does it affect you?) Well it makes you feel really tired...(Int: Mmm) Immeasurably tired... errm, lack energy... and sometimes you can be running to the toilet a lot... (Int: Mmm) Errrm, so... it's kind of... it's kind of debilitating in some ways... 'cause sometimes you need to be near a toilet... you know, you might go back nine times in a morning...which is a lot isn't it? (Int: Mmm) ...and you feel really weak...' [Sophia: P:23. L:11].

James does not go into detail.

'...I've got a thing called irritable bowel syndrome... and I've had it about sixteen years...' [James: P:13. L:8].

Other major illnesses impacting the lives of participants included diabetes and multiple sclerosis.

'(Int: Mmm. And you've got... you've recently been diagnosed with diabetes?) (Cough) Errr, about five years now. (Int: Five years. And how has that affected you?) Errr, (big sigh), well I suppose at the time, it's only type 2... it's not the insulin type.... But that does worry me cause...I don't like needles and I know I couldn't inject myself...' [Jacob: P:13. L:4].

'...I got the diagnosis... multiple sclerosis is a very strange illness and it's hard to diagnose... There is no specific medical test for multiple sclerosis... (Int: Mmm) Errrrrm, it's kind of... they link it to your symptoms...' [James: P:9. L:34].

In addition, Poppy describes the ongoing influence of epilepsy on her life.

'I moved to [Name redacted] and then my epilepsy just started to get worse and worse... (Int: Mmm) ...and if I got too stressed out over something... it would just automatically bring the fits on... I dislocated both my shoulders, I broke my one leg, I broken both my arms as well...' [Poppy: P:11. L:1].

Emotional Health: 'I never had any confidence to be honest'

The majority of the sample described emotional health issues. These broadly cover poor self-efficacy, low self-esteem, shyness, fear and upset with others. The impact has ramifications that influence emotional regulation across the lifecourse (Maughan and Cicchetti 2002). This highlights a sensitivity and vulnerability that can lead to increased risk of psychological distress (Kim and Cicchetti 2010). In childhood, emotional upset stemmed from home, school or the self. Here, Sophia gives an example of how persistent criticism impacts on confidence.

'...she (Mum) used to start picking on me then you know...taking it out on me and belittling me... (Int: In what way?) Well she's just very condescending and rude to me, you know and start picking faults with me and stuff... nothing is ever good enough, you know... So that didn't do much for my confidence...' [Sophia: P:34. L:6].

Some described absorbing emotional upset at home and school.

'I always found that the most, the emotional side of things, the more difficult to handle... Both at home and at school... (pause...) It's the kind of thing that... always managed to eat away at me in a little way... I'm not quite sure how to explain that, but... I guess that different people find different things odd...' [Freddie: P:21. L:18].

Amelia describes the emotional impact of being overwhelmed as a child.

'...I was too scared at the school in Town [name redacted]... I was just so scared you know... It was this huge school... and I just didn't know, you know... and when I... my Mum didn't even take me on my first day...you know... I just had to turn up at this massive school... not knowing where I was going...' [Amelia: P:34. L:26].

Others described their emotional reserve.

'And... I was very introvert...and didn't really say very much...' [Ella: P:27. L:28].

This included recognition of the influence of shyness.

'I suppose I sort of recognised that because I was a shy person myself... I mean it made me shy because I didn't get on with people all that well... I don't know if it was because I was shut away or what it was... but... in the classroom we got on alright... you know? ... I was always a shy person...' [Jacob: P:25. L:18].

Scarlett recalls her shyness within the context of resuming talking.

'...It was really weird, because I'd always been quite shy, even though I was talking again... I was still really shy...' [Scarlett: P:17. L:21].

She had withdrawn talking to anyone unknown during a six year period of middle childhood.

'(Int: Is that for six years you didn't speak?) Yeah... Yeah. (pause)... I don't know why... I don't know why... I just stopped talking... I don't remember making a decision not to talk... 'cause I'd been fairly normal up until the age of three... just, you know... I'd talk like... You couldn't stop me talking...but then... I don't know why I stopped talking...' [Scarlett: P:8. L:3].

In adulthood there is evidence of emotional health being impacted in the same way as childhood. Issues of low self-esteem, low confidence and emotional upset are apparent. Low self-esteem is evident in the following extract from Oscar.

'(teary/crying) I don't know why these things happen to me... I've been special a lot... I'm a special type of person... I was born special... I'm a fuck and a wanker... I don't know any different... I know they can tell 'cause I'm useless... (crying...)' [Oscar: P:21. L:2].

Evie describes being detached from the outside world.

'...I'd say self-esteem was nothing... you know... Absolutely nothing... Nothing at all... I remember we went through a period... I suppose I was isolated...I remember staying on this settee and I thought... I don't want to get off it... I was really, really, really scared... people then stopped coming around my house...' [Evie: P:29. L;23].

A similarity can be made with Isabelle who talks about the emotional impact of being confronted about her mental health problems by a colleague at work.

'I was mad... I just... I just... couldn't take it... I just ran... RAN, RAN, RAN... Out of the room... Out of [work]... out down the back... down these alleyways down the back of the terrace... and I just sort of slithered down the wall and sat there and cried and cried... cried and cried and cried... (softly spoken)' [Isabelle: P:21. L:18].

For some, the emotional legacy from childhood trauma is strongest when confronted by an emotional fragility in adulthood. This may entail reflecting on susceptibility to others or a period of fear. It includes reduced contact or ceased contact with family when a major event occurs such as a death in the family. Each can have a profound effect. Freddie identifies his limited confidence.

'Ohhhhhffff (intake of breath)... I don't know... I just didn't have any kind of, at the time, any kind of... self confidence at the time... to just say 'No'... (Int: Mmm) And she knew that, she could see that... aghhhhhff.' [Freddie: P:27. L:5].

Ella who is estranged from family describes her fragility when learning of her father's death.

'I just didn't feel strong enough to deal with it... and I did really struggle with my father's death... But I hadn't been having counselling... at that time, for a couple of years... and I did go back in to see a counsellor... but I struggled... it was like having unfinished business... And I mean, he died the previous April... I found out the next January... So obviously, the funeral has already happened... and there was just... complicated grief reaction...' [Ella: P:21. L:35].

Others such as Sophia recall periods of real fear similar to Evie above.

'I think the worst time for me has been when I've been going through abuse from people...you know, like when I've been abused by people.. That has been the worst time... when I was younger... (Int: Mmm) ...and errrm, you know, frightened for my life... you know, when I've had difficult situations...people have been very abusive to me... I find that incredibly difficult to deal with on my own.... It opens up the past, you know like, past memories and that... nightmares and stuff...' [Sophia: P:30. L:14].

Continued emotional impact is summed up in a succinct extract from Freddie.

'Huhhh (sigh)... It's quite odd though, because even though things were so long ago, how much they still impact is... you wouldn't believe...' [Freddie: P:31. L:1].

Mental Health: 'I wasn't born with mental health problems'

Mental health was experienced by all participants. For some, it impacted both childhood and adulthood. For the majority it was an impact experienced in adulthood only. A range of diagnoses were described. Similar to the findings in Chapter 1 and Chapter 3 depression featured across the sample as a primary or secondary diagnosis. In addition, more than half of the sample described suffering severe mental disorder or personality disorder. Childhood mental health problems were specifically described as depression. It was not portrayed as a diagnosis but an understanding through a child's eyes. Each child experience will be conveyed here. For example, Isla explains the overwhelming loss she experienced.

'It was hard for me... and I just thought... God, life's too short to be moody and that... because I was depressed and down at that age (9 yrs old), you know... losing my Mom and having to move away from my family...' [Isla: P:22. L:9].

Sophia highlights how emotional tension, victimisation and a traumatic home environment impacted her mental health.

'I became very depressed... 'suicidally' depressed and I ended up in a hospital... I wasn't sectioned... I was... you know... I'd gone to see this psychiatrist and things weren't going too well for me... with my family... situation. That was very stressful and my brother was bullying me and my Mum was stressed out, 'cause my sister has got severe brain damage and it caused quite a lot of tension at home...' [Sophia: P:3. L:7].

Each of the participants with childhood depression continued to experience difficulties into adulthood. The following two extracts express this. The first is Scarlett identifying her age.

'Mmm... I've been... I had my first episode of depression when I was fourteen... Errrm... and it's sort of ongoing... My diagnosis is recurrent depressive disorder... (long pause.....).' [Scarlett: P:4. L:27].

The second is Freddie, recognising the timeframe of his depression across the lifecourse.

'But... to be honest... after talking through it... afterwards... I'll probably admit now that it has been... pretty much since childhood... the issues have always been there... (Depression).' [Freddie: P:6. L:2].

All participants described having mental health problems in adulthood and a formal diagnosis. However, most were confused by, or unaware of their current diagnosis, having had several

applied. It was also apparent that participants did not share a biological understanding of mental distress but favoured more psychosocial explanations such as the negative impact of life events (Read and Harre 2001). For example, this included their lifelong experience of abuse, change in circumstance, physical illness or relationship breakdown. The first extract is James explaining his diagnosis, given forty years earlier.

'A drug-induced psychosis... I had what they call a psychotic reaction to LSD... (Int: How old were you?) (pause...) err, twenty two. Twenty two... yeah, twenty two, twenty three, Yeah twenty two.' [James: P:14. L:10].

He then states current experience.

'Now, I just get down a bit now and then...' [James: P:14. L:17].

Isla gives an overview of her experience of mental health problems, linked to childhood trauma memories.

'It gets us all down. Everything gets us down. Errmm, you see to me, my brain's like a computer and everything is ticking over... everything keeps coming back.' [Isla: P:11. L:21].

Isla states its lasting impact.

'You try to snap yourself out of it... but you cannot... it's easier said than done... It doesn't matter what medication you're on... unless they drug you up to put you to sleep...' [Isla: P:26. L:7].

Sophia identifies her diagnoses.

'Well they said I was suffering from depression and anxiety and I had panic attacks and stuff at the time...' [Sophia: P:25. L:6].

She then considers what she believes causes her poor mental health.

'But it's a bit of a stressful situation to be in, on your own and not feeling (physically) well... you know, and having everything to cope with yourself...and... not have much money coming in, you know... and like, a lifetime of abuse off people...it's not very good is it?' [Sophia: P:25. L:22].

This was also familiar to Ava. In the first extract she appeared bemused by the trajectory to her diagnosis.

'I hadn't ever needed any sort of mental health services... 'til, just over two years ago... and just (uncomfortable laugh) fell apart... and then, yeah, sort of from that... I suppose I was diagnosed with personality disorder... yeah... if that makes sense... (uncomfortable laugh). (Int: Which one? What type..?) Borderline...' [Ava: P:5. L:25].

Later, Ava equates the distressing period with the poignant event of leaving her abusive husband.

'And that's why I just unravelled ha ha (brief laugh)...you know? After I left him...' [Ava: P:21. L:15].

A number of participants listed a range of diagnoses they have received. Some such as Amelia embraced them as an amalgamation of her experience.

'Yeah. I've got personality... Well... I don't know what they mean by personality disorders really...but... post-traumatic stress... sort of anxiety... depression... all sort of linked in... and...and... I've suffered with Bulimia for few... you know... years...' [Amelia: P:9. L:34].

Ella has a similar list but conveys some suspicion over her possible current diagnosis.

'...well there's plainly depression and although there was post-traumatic stress disorder put down, at one point... although they've never...actually told me this... verbally... on the care plan it has said 'other associated personality disorders' (Int: Mmm) ...and that's been on the review thing... But even though you ask, no-one has ever told me that's the diagnosis. It's been on there as a diagnosis.' [Ella: P:16. L:21].

Some appear confused by their psychiatric diagnosis and the treatment offered. Jacob considers his appraisal.

'Well I went to see a doctor about it and he diagnosed me as 'depressive'... but like I say, I didn't think I was, I just have my ups and downs sort of thing... Like I've always been... Eventually he gave me tablets to take... which have been altered about... six or seven times...' [Jacob: P:15. L:5].

The final extract is from Oscar, clarifying his understanding of the origin of his mental health problems.

'All I wanted to do was be in the army. I said put me in the army 'cause I can't be a civilian... and so I started taking drugs... then my mental health problems started. I wasn't born with mental health problems...' [Oscar: P:5. L1]

Summary

Childhood trauma has lifelong consequences that influence the lives of participants in a profound way. Each impact considered here alters personal perspective to further detach from the social world. For most there is an arrested development of academic attainment restricting opportunity for progress and hindering all forms of communication. This adds to a fragility of self that deepens a lack of connection. Self-protection becomes a continuous requirement to the detriment of well being. It appears to take all energy and psychosocial resources to survive. Yet survive they do, but with a burden that is manifest through emotional self-doubt, overwhelming physical breakdown and mental distress that defines their identity. Consideration of all findings, including nature, coping and impact, will be discussed within the context of attachment literature and other theoretical frameworks in the next chapter.

Chapter 13

Discussion

The aim of this chapter is to draw together the principal research findings and discuss how they contribute towards understanding the relationship between childhood trauma and poor mental health in adulthood.

This discussion is organised into four sections: Firstly, research evidence will be discussed demonstrating how experiencing significant trauma in childhood can have a profound impact on social attachments throughout the lifecourse. Secondly, research evidence will be discussed demonstrating how experiencing significant trauma in childhood can lead to additional psychological difficulties, beyond the impact of attachment problems and across the lifecourse. Thirdly, the research evidence discussed in sections 1 and 2 will be combined to propose a new psychosocial model that may help explain why *some people* who experience significant trauma during childhood eventually suffer from mental health problems during adulthood. Finally, section 4 considers some important policy developments that encourage a more direct psychosocial way of working with vulnerable groups.

Childhood Trauma, Social Attachments and the Lifecourse

Participant experience of childhood trauma can be shown to have a significant impact on patterns of social attachment which remain throughout the lifecourse. This evidence will be discussed in terms of each of the three master themes arising from the findings: the nature of traumatic experience, coping and adaptation to these experiences, and the impact of childhood trauma.

The Nature of Childhood Trauma

The findings from this study identified a range of intra-familial forms of abusive conduct (Godbout et al. 2009; Kisiel et al. 2014; Kristensen and Lau 2007). The nature of this trauma covered experiences of physical, sexual, emotional and neglectful abuse (see WHO 1999; WHO 2016; Zlotnick et al. 2008). Moreover, these traumatic experiences did not represent isolated incidents but were typically: pervasive, varied and continuous.

Trauma as Pervasive: All participants experienced familial child abuse, neglect and rejection from a number of significant caregivers. In particular, the main perpetrators were identified as parents, but accounts also include grandparents, older siblings and family friends. This is significant given that caregiver-related abuse has an earlier age of onset, longer duration, is more chronic in nature (Kisiel et al. 2014) and increases the likelihood for multiple abuse experience (Weinfield et al. 2004; Godbout et al. 2009; Alexander 2009). In addition, participants described being completely controlled by their caregivers and restricted in all aspects of their life (Vivona 2000). They were denied inclusion, information and basic rights. Throughout the study, participants reported being ignored, dismissed and abandoned as a deliberate act to undermine their contribution and voice. The imbalance of power was seen through a requirement to relinquish locus of control and comply with the instability of their hostile home environment (Ward and Beech 2006). Further restriction was imposed through enforced isolation from the social world.

It is also evident in the study that abuse was not confined to the familial home but included a traumatic school life. They were targeted by peers and teachers for their social vulnerability (Ney et al. 1994); reinforcing the sense of power others hold over them (Carnelley et al. 1994). For example, peers bullied on a constant, even daily basis, teasing, fighting and rejecting. Teachers belittled, threatened, punished and assaulted. As a result, children may develop a guardedness of others and expectation of rejection and violence from attachment figures (Howe 2005: 83).

Each violation, threat and disregard diminishes the foundation of care and protection necessary in childhood (Godbout et al. 2009; Wilkins et al. 2015). Research suggests caregiver-related abuse is particularly devastating to attachment security of the child (Bifulco et al. 2002b; Ponizovsky et al. 2007; Levendosky et al. 2002; Baer and Daly Martinez 2006; Muller et al. 2012; Weinfield et al. 2004). Indeed, the pervasive nature of these violations distorted all childhood relationships, creating dyadic interactions characterised by mistrust and insecurity which came to dominate all aspects of their personal and social relationships.

Bowlby (1977) believed that affectional bonding with a significant caregiver is necessary for the healthy development of all human beings. For example, children form attachments to adult carers which lead to the formation of affectional bonds. Secure attachment relationships

allow the child to seek proximity with a significant attachment figure as a secure base for comfort and protection. This occurs in certain situations of fear, tiredness or illness (Bowlby 1969). When a significant attachment figure is the cause of distress, it creates chronic hyper-aroused attachment system in a child who has no-one to turn to for consolation (Cyr et al. 2010). Proximity only makes matters worse and is therefore avoided (Howe 2005: 99). Such attachment abuse leads to attachment trauma that damages capacity to access any relationship for security (Howe 2005: 46; Bowlby 1977). This is compounded by a regime of social restriction on environment, mobility and access to others (Berry et al. 2009; Howe 2005), compromising any opportunity of social connection (Hazan and Shaver 1994). As they grow up unwanted, isolated and deprived, they are left totally reliant on the abusive family.

Trauma as Varied: A varied experience of childhood trauma is described in the present study. For example, an extensive range of child abuse associated with adult mental health problems is highlighted. These included sexual (Perales et al. 2013), physical (Muller et al. 2008), emotional abuse (Gibb et al. 2007) and neglect (Green et al. 2010) from a number of significant attachment figures. The varied nature of trauma also occurred through household dysfunction where domestic violence (Green et al. 2010) and parental death (Perales et al. 2013) created further hostility or instability at home. Other adversities identified were parental divorce and parental substance abuse. Although their association with mental health outcomes has no statistical significance in the trauma literature, they were conveyed as significant negative events in some narratives.

Economic adversity featured in the literature with a number of studies identifying an association with adult mental health problems (Green et al. 2010). This appeared to depend on age of adversity being late adolescence (Perales et al. 2013) and mainly related to the experience of men (Putnam et al. 2013; Pirkola et al. 2005). This may indicate why it was not an overt factor in the present study, given the earlier onset of any adversity and gender ratio of the sample. However, it was present in a number of narratives that described living in squalor and poverty. Some mentioned that being poor added to their visibility as socially vulnerable.

In addition to the varied range of trauma identified is the combination of multiple traumas. For example, all participants identified a minimum of three traumas, with the majority detailing

four or more (Chapter 10: Table 10.1). This is also evident in the literature and in particular, clinical populations. A number of studies found that over half report multi-type trauma, with a minimum of three and four reported by one in five (Moskvina et al. 2007, Sesar et al. 2010). Indeed, multiple traumas are the norm for a number of trauma types, but especially child abuse (Gibb et al. 2007). The most common co-occurring traumas reported in a clinical population are child emotional abuse and any other form of child abuse (Bifulco et al. 2002, Gibb et al. 2007, Spertus et al. 2003) and child physical abuse in particular (Moskvina et al. 2007; Sesar et al. 2010). This was also true for domestic violence and any child abuse when related to insecure attachment (Levendosky et al. 2002).

The experience of varied trauma across childhood and in all aspects of life impacts self-identity and the ability to process attachment experiences (Booth-Laforce et al. 2006). Instead of loving connections with significant caregivers, participants recall fear, danger, and unpredictable attachment encounters through their varied experience of multiple abuse. As such, the attachment bond is severed (Howe 2011), leaving the child believing themselves to be helplessly unprotected (Crittenden 2002: 121). The result is the formation of insecure attachment with all caregivers (Berry et al. 2009; Kiesel et al. 2014) that can impair development physically, educationally and emotionally (Howe 2005).

Trauma as Continuous: Within the findings, there are two aspects that provide evidence of trauma as a continuous rather than discrete feature of the lived experience of each participant. The first is incessant nature of trauma experienced at home and school from an early age that was negotiated on a continuous, daily basis. Childhood trauma is rarely a one-off event or limited to a specific time-period (Price-Robertson et al. 2013). Instead, it is clear from the narratives how imbedded trauma is in participant lived experience across the lifecourse (Godbout et al. 2009). The literature focuses on increased risk of lifetime trauma through a combination of factors. These include the initial perpetrator being a caregiver (Kristensen and Lau 2007), the type of trauma being abuse (Maniglio 2012), an earlier age of onset (Moskvina et al. 2007), longer duration (Kiesel et al. 2014) and multiple abuse experience (Moskvina et al. 2007, Sesar et al. 2010). This combination has a significant presence in the majority of narratives across the study.

The second is that trauma is not confined to childhood (Berry et al. 2009). The findings identify continued vulnerability to others through inter-generational cycle of maltreatment. The perpetual nature of familial abuse is high, with abusive parents being replaced by abusive partners in the form of intimate partner violence (Weinfield et al. 2004; Busuito et al. 2014). Many also provided accounts of their children engaging in physical and psychological abuse towards them. In essence, narratives provide insight into a traumatic lifecourse with descriptions of continuous experience of abuse in all areas of their lives. Not only intimate familial betrayal, but accounts of psychological cruelty from attachment encounters in the social world from peers, neighbours and even authorities whose job it was to provide help.

Continued malicious disruption to bonding has an enduring impact on attachment security (Baer and Martinez 2006; Schimmenti and Bifulco 2013) and integrative functioning into adulthood (Neufield Bailey et al. 2007; Kisiel et al 2014; Sigurdardottir and Halldorsdottir 2013). Perpetual trauma experience may also be influenced by expectation, based on previous trauma (Bowlby 1980). Research has found that children with trauma history and insecure attachment are socially withdrawn, dependent and less socially competent; which meant being unpopular, victimised and ultimately rejected by peers (DiTommaso et al. 2003; Finzi et al. 2000). It is suggested this continues into adulthood when the insecure attachment style remains fixed (Weinfield et al. 2004). This appears apparent in the current sample, where opportunities to develop a more secure status are diminished by continued poor attachment relationships (Muller et al. 2008) and subsequent inability to navigate adult milestones (Caspi and Elder 1988).

Coping and Adaptation to Childhood Trauma

The findings identify a range of coping strategies employed in response to the distressing experience of trauma. The following discussion will draw on findings from the superordinate themes and is organised around three areas that include, Avoidance, Construction of an Imagined World and Retaliation.

Avoidance: Overall, participants described attempts to protect themselves against their everyday experience of trauma by seeking support or avoidance. Narratives are primarily based on unsuccessful attempts to gain support, with caregivers unreliable, unpredictable or unresponsive.

Avoidance of threat was one of the main options available through a high degree of energy placed on social isolation. At home, most mentioned hiding from abusive caregivers and ‘treading on eggshells’ to avoid attention. School was no better, where persistent bullying resulted in developing a ‘safety plan’ (Black et al. 2010). This entailed a constant state of arousal in avoiding others by locating safe environments to hide and safe routes to and from school. Isolation was also reinforced in school through a lack of academic ability and even through academic success for a small number (Zionts 2005: 237). As trauma experience continued into adulthood, one major protective factor is how isolation in their current home environment enables avoidance of others. This is illustrated by a lack of engagement with neighbours being a positive measure of their neighbourhood.

In the absence of adequate care and protection they are forced to self-protect. This is achieved through controlling behaviours (Crittenden 1999); strategies that direct the dangerous, vulnerable or out-of-control attachment figure in the interaction. Their purpose is to reduce danger through a compulsive self-reliance, rather than social connection (Crittenden and Claussen 2000; Howe et al. 1999: 70). Also, reduce any control the attachment figure has on the relationship (Howe 2005) through emotional distance and avoidance (West and George 1999). Adapting behaviour to avoid attachment encounters becomes necessary in an attempt to protect the self. Avoidance is presented as the only route to feeling safe (Howe et al. 1999: 138). Unfortunately, the result is further cementing their isolation by casting themselves outside family, group and community, causing great anxiety (Howe 2011: 6). In addition, the consequence of such action limits any opportunity for actual or potential attachment bonding (Bowlby 1977).

Construction of an Imagined World: In order to compensate for loss of connection with others, coping moves to maintaining the self through a form of reality-blocking. Findings are interpreted as attempting to bridge isolation by combating negative reality through the construction of an imagined world. This provides an existential safeguard through detachment and presents re-evaluated social normality (Myers and Derakshan 2004; Mancini and Bonanno 2009). This is manifest in several ways, but mainly characterised through a cognitive strategy of positive appraisal for negative circumstances (Kilburn and Whitlock 2017). For example, narratives detail a revised positive perception of abusive caregiver. This included the view of an abusive mother as an ‘angel’ and belief in being a favoured child of an abusive father. Also,

some exaggerated less supportive aspects of life, such as basic food and clothing being a measure of received, successful support. Yet, caregivers were completely unresponsive to their emotional needs. This self-serving bias of perception promotes coping as part of a story of survival (Bonanno 2005). It is self-deception that avoids emotion (Weinberger 1990), and avoids negative self-relevant information (Myers 2010).

Repressive coping is also defined through self-enhancement (Sedikides et al. 2003) to compensate negative traumatic influence and restore control (Taylor and Armor 1996). For instance, individuals show tolerance of events, proof of independence and necessity for outward appearance of confidence in order to self-protect (Arkin 1981). This was evident in the self-denial of actual friendship status. For example, friends are subjectively described as close, regular, continuous and accessible, when they appear objectively distant, irregular, unavailable and transient. No real connections were gleaned from the interviews. Friends are described as replacing professional assistance, but never discussed in a social context, with a social function.

Finally, many make sense of their traumatic childhood experience through a form of sense-making that alters the narrative of child abuse to move from victim to survivor (Montalbino-Phelps 2004). This is evident in the study through fatalistic perception of events as understandable, in home environments where violent abuse was common place (McFarlane et al. 2014). It also includes magical thinking (Howe 2011: 147), where negative outcome is accepted as a formality and somehow provoked by the participant (Biank and Werner-Lin 2011).

Although historically seen as maladaptive dissociation in attachment theory (Bowlby 1980), contemporary research considers repressive coping an adaptive strategy that promotes resilience (Coifman et al. 2007; Mauss et al. 2006). Repressive coping highlighted a disowning of the vulnerable self by repressing the reality of childhood trauma and poor attachment history (Howe et al. 1999). What appears evident in the study is that the imagined world of repressive coping is a reconstructed attachment system. For example, accounts reveal a combination of self-deception through repressive coping (Weinberger 1990) and a fearful-avoidant internal working model (Mikulincer and Shaver 2012). This is actualised through a fear of disclosing vulnerability, which at first appears conscious. However, it is actually

autonomic and outside of conscious awareness (Boden and Baumeister 1997). Subjectively they self-appraise their social restriction favourably (Newton and Contrada 1992, Myers 2010), whereas, outwardly they describe the continuation of poor social attachment to others. Representations of insecure self as vulnerable and helpless are thus disowned (Allen 2001), replaced by improved self-evaluation.

Retaliation: Retaliation against self is an immediate reaction to trauma. For example, with poor caregiver relationships and no-one to turn to for support, participants can turn on themselves. In childhood, it manifest mainly as giving up on self by not trying at school. In adulthood, retaliation against self was dominated by suicidality. It included suicidal attempt, either planned or spontaneous (Low et al. 2000), or suicidal/death ideation (Smith et al. 2012) and always followed a significant social incident or transition. As identified in chapter 3, history of child abuse significantly increases the risk of suicidality (Finzi et al. 2002; Kisiel et al. 2014). In particular, those with a history of child sexual abuse (Smith et al. 2012) or child physical abuse (Finzi et al. 2002) are at greater risk. Although suicidality had a limited presence in the literature, it is perceived as a consequence; whereas, in the present study it serves as an important strategy in reinforcing an element of control. For instance, knowing there is an escape can make it easier to continue for some (Lakeman and Fitzgerald 2008).

Retaliation against others is a show of defiance to maintain or regain control over childhood events. In childhood it manifest as empowerment through anger rumination (Sukhodolsky et al. 2001), delayed fantasy of revenge (Ornstein 1999), emotional withdrawal (Stroufe 2003) and for some, responding in kind (shouting back). As children, there is no resolution to their retaliation. As a result, dysregulation of hostile emotion can inhibit mature development for restraint in adulthood (Atkins et al. 1993). This can lead to continued hostility and vigilance to thwart further risk of trauma (Renn 2003). Evidence is provided in their violent preparedness for self-defence from actual retaliation such as violence or potential threat, such as carrying a knife.

Against self is interpreted as reaffirming an unworthy sense of self through self-harm (Van der Kolk and McFarlane 2007: 11). To protect the vulnerable self, deactivation from the attachment figure becomes more severe (Bowlby 1980; Stroufe 2003; Howe 2005). Unable to tolerate negative attachment encounters leads to suicidality as a coping strategy (Keisel et al.

2014). For preoccupied attachment style, suicidality can maximise the possibility to engage the attachment figure and draw them closer. For fearful-avoidant style, it ultimately highlights their lack of need for the attachment figure. This was also evident during the interviews, where participant description of suicidality was detached and seemingly nonchalant. For some, such indifference protects the vulnerable self in the face of social judgement (Howe et al. 1999). For others it serves as an important strategy in reinforcing an element of control (Lakeman and Fitzgerald 2008). Against others is interpreted as unresolved anger (Neuman 2012), manifest from childhood trauma history (Schimmenti 2012).

Coping strategies and preventative measures are not featured in the research identified in this study, where the main focus is based on consequence and impact. As such, there is a gap in the literature with regards to the coping strategies employed here and described in chapter 11. A definite demarcation exists between direct response to trauma across the lifecourse and lasting impact resulting from childhood trauma and failed coping. Therefore, coping literature has been considered here that fits the specific preventative measures identified in the study.

The Impact of Childhood Trauma

Consequences of childhood trauma are mainly understood through a breakdown in personal and social world. The findings elicited profound difficulties in self-identity, connection with others, isolation from the outside world, poor health and reliance on outside agencies for support. The following discussion draws from the superordinate themes in chapter 12 and will be organised around three areas, namely, Fragile Self Image, Marginalisation and Poverty of Psychosocial Wellbeing.

Fragile Self Image: Perception of self and others is distorted through negative traumatic experience of childhood. This leads to a negative self-appraisal consistently expressed throughout the study via negative self-image (Van Harmelen et al. 2010), self-blame for loss (Barker-Collo 2001), self-blame for maltreatment (Liem and Boudewyn 1999), negative self-worth (Cook et al. 2005), and a lack of existence (Sanderson 2006: 52). This fragile sense of self impacts all aspects of participant life and restricts future outlook. In childhood most have no release, no confidant and no options. As such, internal attribution of blame and influence ensues. This is compounded by complete mistrust of others, vulnerability to further trauma and fear their fragility is visible (Jones et al. 1984). In adulthood, their negative self is portrayed

as a 'defeated self'. They often demeaned their value and contribution and expressed self-loathing. With a lack of future evident in the sample and limited present activity, they are locked into their past. Fragility is also evident through a persistent vulnerability to others that remains lifelong (Mallinckrodt and Wei 2005; Dimitrova et al. 2010) and promotes resulting loneliness (Pielage et al. 2005; Wiseman et al. 2006). If the fragile self lacks self-efficacy it becomes more difficult to protect, resulting in social and interpersonal 'resource loss' (Walter et al. 2010), vital for wellbeing and survival.

Fragile self-image is identified in connection with insecure attachment style and influence of internal working models of self and others. For example, attachment style is developed in childhood through the internalised experience of infant-caregiver attachment relations (Bowlby 1973). Healthy, stable attachment experience leads to secure attachment style. Unhealthy, unstable attachment experience leads to insecure attachment style. In the present study it is estimated the majority presented with fearful-avoidant attachment with unresolved trauma and the remainder, preoccupied attachment style (see Appendix 2a). Both exhibit a negative working model of self (see Appendix 10a) that represent the self as worthless and inadequate (Webster et al. 2009), unable to form affectional bonds (Bowlby 1980). Its disruption remains a feature across the lifecourse (Crittenden and Ainsworth 1989) and can only be rectified by improved, safe attachment experience. Instead, their threatening and unpredictable social world (Hankin 2006; Raque-Bogdan et al. 2011) reinforced negative self-perception and fear of the other as 'superior' (Bowlby 1980). It also invokes a chronic sense of insecurity that does not abate (Weinfield et al. 2004; Godbout et al. 2009; Busuito et al. 2014).

Marginalisation: Marginalisation is evident through physical and emotional isolation from others. Accounts describe how individuals adopt the role of loner across the lifecourse, from coping through avoidance to the impact of social marginalisation. Resulting isolation includes circumstantial limitation, total withdrawal and ensuing loneliness. A clear example is through intergenerational detachment from parents, siblings and even their own children. Objectively, they have no close relationships with anyone (Smith et al. 2012; Ognibene and Collins 1998; Bifulco et al. 2002b) and lack social competence to form relationships (Reinert and Edwards 2009).

Marginalisation is further compounded by an educational deficit that impacts all aspects of their lives (Marcus and Sanders-Reid 2001). In childhood, participant accounts describe inadequate reading and writing skills that left them unable to compete with peers (see Mersky and Topitzes 2010). Some were removed from mainstream education to attend 'special education' (Jonson-Reid et al. 2004). They referred to themselves as 'backward' with familiarity. However, evidence suggests poor educational attainment is linked to child maltreatment (Lansford et al. 2002; Gelles and Perlman 2012; Jonson-Reid et al. 2004; Slade and Wissow 2007; Hutzell and Payne 2012). Most expressed a vehement dislike for school which impacted their engagement and school completion (Marcus and Sanders-Reid 2001). Educational deficit remains into adulthood, causing long-term social and economic deficit (Currie and Widom 2010), and limiting communication and educational achievement (Gilbert et al. 2009).

Marginalisation starts in early childhood attachment experience. For example, children with an emotionally detached or unpredictable caregiver learn not to seek comfort or safety when upset or frightened (Howe 2005: 99). Instead they attempt to care and protect themselves at home and school. Any support they do gain is insufficient and irregular. This leads to negative expectation of support (Liotti 1999; Muller et al. 2008), reduced capacity for help-seeking (Larose and Bernier 2001; Zwaanswijk et al. 2003) and poor educational attainment (Veenstra et al. 2010). They are ignored and their perceptions denied, leaving them in self-doubt as to their own sense of reality (Bowlby 1980). In an attempt to gain some control they deactivate attachment and disengage (Howe 2005). This is evident in coping through avoidance that leads to the impact of marginalisation from all attachment relationships.

To compensate for the reality of such devastating impact, participant narratives detail an expansion of their imagined world through the formation of three new forms of distorted attachment. The first is altered perceptions of friendship attachment. Although perceived friendships can take on a buffer role from abusive family (Powers et al. 2010), they are not usually stable relationships. Instead, transient friendships and poor attachments are described as good friendships. The second is attachment to their environment. They conveyed a stronger attachment with their isolating neighbourhood than to people (Kyle et al. 2004). This 'place identity' appears to help construct self-identity through their residence (Raymond et al. 2010) and a 'place attachment' (Rollero and De Piccoli 2010) that provides comfort and safety

(Hidalgo and Hernandez 2001). The third aspect is use of technology in establishing remote social attachment. Use of email, texting and telephone access and social media defined social connection (Lee 2013) and imagined intimacy with online, social media 'friends' (Greenwood and Long 2011).

Poverty of Psychosocial Wellbeing: Participant narratives identified impact on their wellbeing to include physical, emotional and mental health. A small number experienced physical problems in childhood that created traumatic disruption from their caregivers due to long periods of hospital treatment. However, most accounts highlight difficulties in adulthood. For example, serious physical difficulties were described as the main problem that impacted their daily life. All conditions are linked to pain sensitivity, including migraine, fibromyalgia (Frías and Shaver 2014; Scheidt and Waller 2015) and irritable bowel syndrome (Ben-Israel et al. 2015). Some connected their internal physical pain with the pervasive influence of childhood trauma, a physical manifestation of psychological pain (Imbierowicz and Egle 2003; Lyons-Ruth et al. 2007). In addition, emotional dysregulation is evident across the lifecourse (Maughan and Cicchetti 2002) through internalising and externalising behaviours discussed in fragile self-image and retaliation. Its impact also exposes the vulnerable self to increased risk of psychological distress (Mallinckrodt and Wei 2005; Kim and Cicchetti 2010).

The inclusion of mental health problems compounded poor psychosocial wellbeing, mainly through the experience of depression. This was also evident in the literature, where depressive disorders have the highest prevalence with childhood trauma (Ivarsson et al. 2010, Bifulco et al. 2002a). In addition, similar to the current sample, psychiatric populations have the addition of schizophrenia disorders (Alvarez et al. 2011; Kristensen and Lau 2007; Saleptsi et al. 2004; Maniglio 2013; Duhig et al. 2015) and personality disorders (Kuo et al. 2015). This compares to community studies where they have little or no presence (Chen et al. 2010).

Whilst the sample share a similar diagnostic profile to the clinical population discussed above, participant acceptance of psychiatric diagnosis was not straight forward. The majority appeared to favour psychosocial explanations for their mental distress, rather than a biological one. For example, when discussing their experience of depression they portrayed an understanding through the negative impact of life events (Read and Harre 2001). These mainly included emotional upset with relationship breakdown, grief reaction to loss and distress with

trauma experience. However, a psychiatric diagnosis can redefine social identity (Crawford and Brown 2002) through a new function as 'mentally disabled'. This is devastating to many, rendering them powerless to change circumstances that brought them to psychiatric attention (Read 2004: 168). It can mean being devalued and excluded; considered unpredictable, dangerous and incapable of living an ordinary life (Repper and Perkins 2003: 15; Angermeyer and Matschinger 2003). As described in the findings here, stigma and discrimination also ensue (Corrigan 2004). First felt in the family, the experience extends to agencies meant to support and protect (Simmons 2001; Corrigan and Bink 2016). Ultimately, social rejection can lead to internalised self-stigma (Corrigan et al. 2006; Park et al. 2013) and reduced social attachment (Yang et al. 2010).

Childhood Trauma, Additional Explanatory Influences and the Lifecourse

This section will explore the relevance of other theoretical frameworks that offer an additional explanation beyond attachment theory. Although there are several alternatives discussed in chapter 2, three emerged as relevant to the findings of this study and form the structure of this section, including Cognitive Theory, Hopelessness Theory and the Theory of Resilience.

Childhood Trauma and Cognitive Theory

Cognitive theory is identified in several aspects of the findings of this study. For example, across the sample there is evidence of functional deficit, impacting memory and learning (Squire et al. 2004; Joubert et al. 2012). Most often this is explained by early trauma experience (Hedges and Woon 2011). There is also evidence of distorted perception through what Beck et al. (1963) term dysfunctional schema. The following discussion will be organised into three areas, including Developmental Delay in Learning, Developmental Delay in Memory and Dysfunctional Schema.

Developmental Delay in Learning: Maltreated children exhibit academic delay with reading and writing and struggle with a range of communication skills such as language, speech, attention and executive functioning (Beers and De Bellis 2002; Bremner et al. 1995; De Bellis et al. 2009). This results in cognitive and academic delay remaining into adulthood (Navalta et al. 2006; Perez and Widom 1994; Trickett and McBride-Chang 1995) and impacting all aspects of communication. In the present study, participants detail failed academic engagement

(subordinate theme: Limited education), with most leaving school with poor academic attainment and no qualifications (Boden et al. 2007; Gilbert et al. 2009). A number attended 'special' education for their learning needs as a result of arrested development that some believe stems from childhood trauma (Daignault and Hébert 2008; Veltman and Browne 2001).

Developmental Delay in Memory: Childhood trauma impacts on the process of recording conscious autobiographical memory (Dillon et al. 2014). This leads to a reduced ability to process through thought or regulate through language (Courtois and Ford 2009). Instead, unresolved distress is associated with physical and emotional dysregulation (Dillon et al. 2014) that influences working memory (Joubert et al. 2012). Memory deficit was not overtly identified in the study. However, physical difficulties are apparent and consistently described as overwhelming all aspects of participant life (subordinate theme: Physical Health). In addition, emotional stability is compromised and influences ability to function (subordinate theme: Emotional Health).

Dysfunctional Schema: In cognitive theory distorted perception is identified as dysfunctional schema (Beck et al. 1963). Early trauma alters appraisal of self and others in the form of negative systematic biases at the core of depression (Beck 1976; Sethi 1964). There are two forms of bias, both of which are present in the findings. The first is attentional bias identified through preferential attending to content-specific events (Bentall and Kaney 1989) and threat-related stimuli (Moradi et al. 1999). Participant descriptions identify a fragile self-image vulnerable to the threat of others, reinforced by preparation for retaliation through self-defence. The second is attributional bias whereby positive and negative events are explained through internal or external causation (Fiske and Taylor 1991; Kaney and Bentall 1989). They are self-serving errors that attribute positive events as internal influence of self and negative events as external influence of other. However, this can reverse in people with depression through a negative triad of irrational pessimism regarding self, the world and future (Beck et al. 1979). This is evident in the narratives throughout the study. Accounts detail self-blame for events, negative influence from the world they encounter and a lack of future.

Childhood Trauma and Hopelessness

There are two main aspects to evolve from a sense of hopelessness and both are present in the findings of this study. The first is hopelessness depression (Abramson et al. 1989) and the

second is hopelessness as a psychological mind-set experienced by suicidal persons (Shneidman 1998).

Hopelessness Depression: An attributional style of thinking is associated with the onset and maintenance of hopelessness depression. This is manifest through an expectation that desired outcomes will not occur or aversive outcomes will occur. There is no sense of hope that anything will change the situation for the better. Iacoviello et al. (2013) found that hopelessness was followed by a number of debilitating symptoms such as feelings of self-blame, worry, decreased self-esteem, and dependency. All of these aspects have been detailed within subordinate themes of Negative Self and Emotional Health (chapter 12). Dependency is not explicit in the study but implied. Only one participant has employment and so, most depends on health services and local mental health charities to meet a range of needs. Hopelessness theory is also associated with childhood adversity (Read et al. 2001) and with increased likelihood, following three or more adversities (Haatainen et al. 2003).

Hopelessness Suicidality: People become trapped within a psychological state of feeling a pervasive sense of hopelessness, lacking any future and having no way out (Shneidman 1998). Such negative perspectives were consistently expressed here. The overwhelming majority described having depressive symptomatology, see subordinate theme: Mental Health (chapter 12), whether formally diagnosed or not. In addition, many stated they had no future, see subordinate theme: Negative Self (chapter 12) and most have limited options in their life. Hope is minimal and has led to suicidal behaviour, see subordinate theme: Against Self (chapter 11). A large number attempted suicide (O'Connor et al. 2000), others have had suicidal ideation (Huen et al 2015), and some wished to hasten death (Breitbart et al. 2000; Kattimani et al. 2015). A study by Smith et al. (2006) considered duration of suicidality, from the emergence of suicidal ideation to actual attempt. They determined that hopelessness and rumination are central and important predictors of suicidal thinking, but hopelessness is the most important predictor of length of suicidality.

Childhood Trauma and Theory of Resilience

The theory of resilience is based on two main concepts. The first is severity of adversity and the second is positive adaptation (Fletcher and Sarkar 2013).

Severity of Adversity: The severity of adversity will determine the level of competency needed (Davydov et al. 2010). Within the present findings, the level of severity is such that participant accounts depict a struggle with competency. It is evident that resilience adaptation is required in maltreated children through what Cicchetti (2010) terms, resilience over-control. This is adopting a more reserved and controlled way of interacting and relating. This is enhanced through conscious reappraisal of traumatic events in a positive light (Gross 2002) and demonstrating stable levels of functioning despite severe adversity (Poole et al. 2017). The participant experience of adversity is severe, pervasive, continuous and detrimental to any form of resilience and yet they survive on limited resources and adaptation.

Positive Adaptation: There is a capacity to thrive after adverse events through a variety of pathways to resilience (Bonanno 2004). Participants have limited personal resource and so, repressive coping is used as an adaptive strategy to promote resilience (Coifman et al. 2007; Mauss et al. 2006). This was evident across the findings, whereby, an imagined world provides a positive and protective adaptation to the severity of traumatic experience. Resilience is evident through strategies of self-protection to adapt perception or behaviour as mechanisms of survival (Glenn 2014). Accounts detail a high tolerance for the intolerable throughout their lived experience of trauma, coping and impact. Whether through positive reappraisal, self-enhancement, self-segregation, or repressive coping, self-protection is ensured. This may activate a sense of self-agency (Van Vilet 2008), which Corona Radiata (2013) suggests may be accurate or inaccurate, it may be crisp or fuzzy, but some sense of agency is essential. Whichever pathway is undertaken, resilience mitigates long-term risk of depression (Poole et al. 2017) and suicidality (Roy et al. 2011).

Psychosocial Crisis of Self and Poor Mental Health

This section combines the research evidence discussed in sections 1 and 2 in an effort to formulate a new psychosocial model that may help explain why **some people** who experience significant childhood trauma eventually suffer mental health problems during adulthood. The section will present the new explanatory model and the discussion is organised around the framework presented in figure 13.1 below.

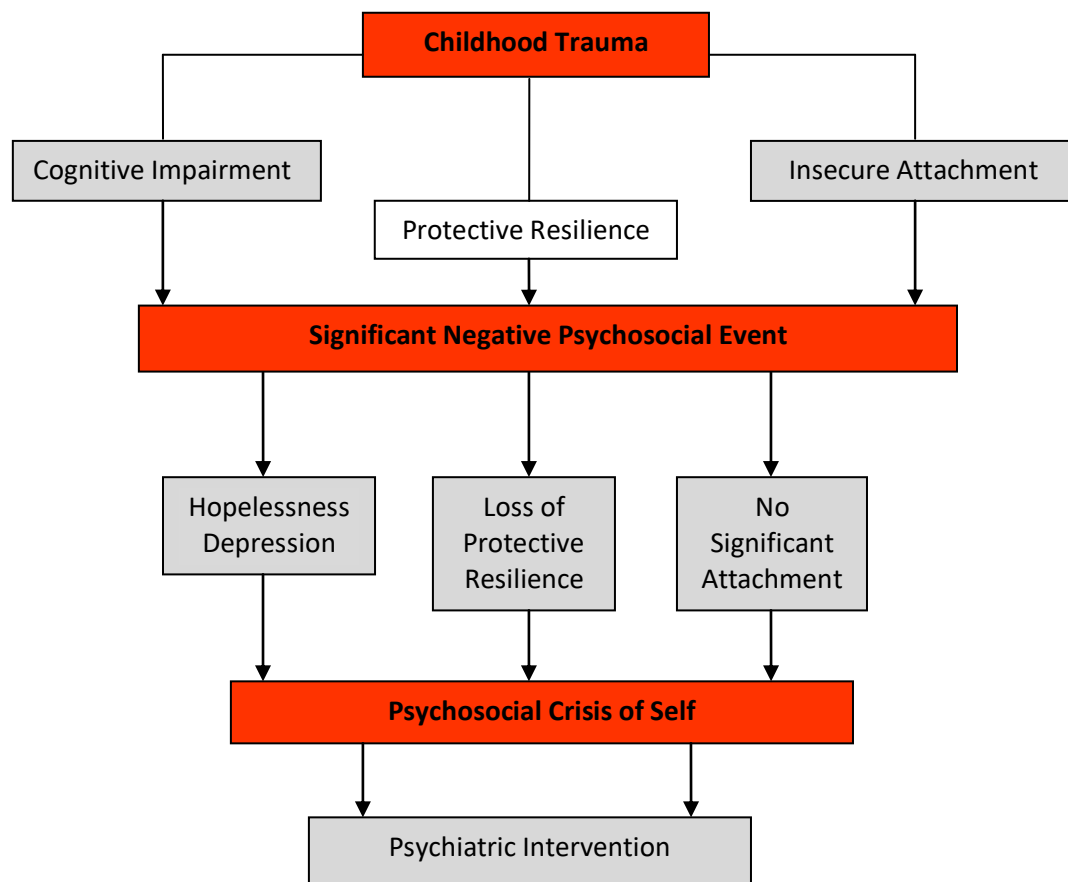


Figure 13.1: Psychosocial Crisis of Self

Towards a New Explanatory Model

This new explanatory model is an interpretation of the findings of this study that illustrates a number of key transitional stages influencing the negative trajectory some people navigate following childhood trauma. It attempts to offer an explanation of how each stage contributes towards the next stage, culminating in the need for psychiatric intervention. The pathway is indicative of the progressive nature of experience, but does also represent flexibility of individual experience. It is by no means strictly linear. For example, hopelessness depression may present earlier in the process but mitigated by resilience, or the significant negative psychosocial event could occur in childhood. In the following discussion, key aspects of each stage are identified as influencing the pathway to psychosocial crisis of self and psychiatric intervention.

Childhood Trauma: The findings of this study highlight the pervasive nature of the childhood trauma they experienced. Each participant shared graphic accounts of child sexual, physical, and emotional abuse, and neglect from significant attachment figures. Caregiver abuse started at an early age, had a long duration and was chronic in nature (Kisiel et al. 2014). Abuse was described as multiple (Weinfield et al. 2004; Godbout et al. 2009), involving a number of perpetrators across their home and school life. It was pervasive, varied and continuous. Any opportunity to grow and develop socially was denied by caregivers (Hazan and Shaver 1994), who controlled and restricted autonomy (Vivona 2000). What appears to follow such insidious child maltreatment is the development of insecure attachment and cognitive deficit, with protective resilience providing a form of counterbalance to support survival. These form the next stage of the model.

Psychosocial Influence of Insecure Attachment, Cognitive Impairment and Protective

Resilience: Following the brutality of familial violence and damaging child abuse, participant accounts highlight three psychosocial influences. The first, *insecure attachment style* is manifest through a complete breakdown of attachment experience with significant attachment figures (Bowlby 1973; Berry et al. 2009), negatively impacting all relationships (Kisiel et al. 2014). Fear of attachment encounters and lack of social competence (Bowlby 1980) leaves them completely marginalised from any meaningful connection with anyone.

Second, such debilitating detachment is further compounded by *cognitive impairment*. As such, they struggle with communication skills and executive functioning (Bears and De Bellis 2002; Bremner et al. 1995; De Bellis et al. 2009) that leaves them unable to compete with peers (Mersky and Topitzes 2010) and are ultimately rejected (DiTommaso et al. 2003). They are isolated, uneducated and lack any kind of supportive relationship, friendship (Berry et al. 2007) or confidant (Bifulco et al. 2002b).

Protective resilience is the third influence identified as being present in all participant narratives. Its influence appears to improve the ability to endure childhood trauma impact and subsequent attachment and cognitive deficit. While resilience theory discusses positive adaptation (Fletcher and Sarkar 2013), what appears evident here is a form of protective survivor adaptation. Although somewhat tenuous it does promote a level of psychological resilience to survive (Newsom and Myers-Bowman 2017). In this case, resilience refers to the

capacity to adapt 'successfully' to disturbances that threaten viability, function, or development (Masten 2014). Their coping includes strategies of self-protection such as avoidance of attachment encounters and an imagined world employed as an alternative to stark reality of isolation.

Significant Negative Psychosocial Event: Evidence from the findings indicates that a *significant negative psychosocial event* occurs, where the participant suffers a change in circumstance. This event or sequence of events has a catastrophic impact on the individual. Events are most often a devastating breakdown of personal attachment relationship (partner/relative) or breakdown of social attachment relationship (employment/university) (Bostik and Everall 2006; Keisel et al. 2014). The ramifications may be far-reaching both emotionally and physically. For example, enforced change to living situation, familial disruption through separation from partner/children, or loss of earnings or future direction. Although participant accounts detail a multitude of adversity, this appears to be a transitional point reached whereby their world collapses and they suffer a complete loss of stability. This is characterised through combined hopelessness explored in the next stage.

Combined Hopelessness of Hopelessness Depression, Loss of Protective Resilience and No Significant Attachment: Following the significant triggering event, a combined hopelessness appears to totally debilitate the person through three overwhelming influences. For example, *hopelessness depression* renders the person trapped in a psychological mind-set that nothing will change for the better. They have no sense of hope and appear consumed by the force of negative depressive symptoms (Iacoviello et al. 2013). Such hopelessness is reinforced by their lack of meaningful connection to a *significant attachment* figure. This is important, given it brings their isolation into acute focus. They are unable to tolerate, contain or soothe their distress and have nowhere to turn and no-one to turn to (Howe 2005: 146). The *protective resilience* that provided a level of survival adaptation to extreme adversity, albeit tenuous, appears to dramatically drain. This not only leaves the participant overwhelmed by the significant negative psychosocial event, but can expose them to the reality they vehemently defended against. This leads to a psychosocial crisis of self.

Psychosocial Crisis of Self: Combined hopelessness following the significant negative event leaves the person plunged into the midst of a psychosocial crisis of self. What appears to occur

is a complete disintegration of endurance and inability to fend off the crashing realisation of their current plight. They are now placed in immediate danger of actual or potential self-harm through the inclusion of hopelessness suicidality. Their new psychological state combines depression, lack of future and no way out (Shneidman 1998). For the majority, this resulted in either actual suicide attempt (Finzi et al. 2002; Low et al. 2000) or suicidal/death ideation (Smith et al. 2012). For a small number it was self-harm through significant substance abuse of illicit psychoactive drugs such as crack cocaine and LSD (Anda et al. 2006). Evidence from the findings suggests most are introduced to mental health service intervention following a change in their behaviour that alerts GP services to suicidality, hospital admission for suicide attempt or via police referral.

Psychiatric Intervention: Psychiatric services can offer a place of safety and medical treatment to ease emotional distress. For many this was provided voluntarily and for others, it was enforced through the use of mental health law. Typically, psychiatric services in the form of psychiatric admission, medication and diagnosis, shapes the person within the framework of a biomedical model. Yet, the evidence from this study indicates the history of their lifecourse from childhood to adulthood, is governed principally by psychosocial difficulties. In order to consider change in some small way, the next section identifies policy implications that may assist in adapting and improving current practice.

Policy Implications

Policy and practice implications are considered to promote the emphasis of psychosocial focus in mental health care. Any suggestions are also identified within the constraints of contemporary austerity restrictions on services. To achieve this, four key areas will drive the perspective forward. They include a Greater Psychosocial Emphasis, Mental Health Assessment, Attachment-Based Strategies, and Enhance Personal and Social Resilience.

Greater Psychosocial Emphasis: Currently the most dominant paradigm in mental health care is the biomedical model. This model posits that mental illness stems from a brain disease that requires medication to target biological abnormalities (Deacon 2013). Its influence continues to dominate science, policy and practice in healthcare (Deacon 2013). In particular, the expansion of psychiatry has been based on promoting drug treatment as a cure-all for multiple

problems (Double 2002). Critics of the system like Carpenter (2002) believe that the biomedical model has been a driving force in policy and service provision to the detriment of service user self-efficacy and sense of hope. This is due, in part, to the fact that it cannot fully explain many forms of illness (Wade and Halligan 2004) and has failed to complement a biological view with psychological and social understanding (Double 2002). For example, the life-long experience of abuse and trauma through unhealthy relationships, social rejection and a lack of connection are not easily addressed via a medical model. It seems evident that a psychosocial model will assist in lifting people out of such a marginalised existence. Not at the exclusion of all other models, but rightfully incorporated into the long-term psychosocial recovery of the individual.

In the present study, participant explanation of their mental health problems was identified through a range of challenging psychosocial factors. Although perhaps out-of-step with medical understanding, their experiences are similar to public perception that challenging experiences create mental health problems (Read et al. 2013; Haddock et al. 2014; Yamaguchi et al. 2013). There is evidence to reinforce the influence of psychosocial factors on mental health recovery. Three areas are central, namely: empowerment; connectedness; and rebuilding a positive identity (Tew et al. 2012). Therefore, it seems timely that psychosocial needs are included in all psychiatric interventions, including assessment, intervention, care and protection.

Policy and practice needs to reflect an endeavour to promote the psychosocial value of the individual as a member of community and society. Indeed, a number of key stakeholders are advocates of an ideological shift towards a psychosocial model in mental health care. They include NHS England (Mental Health Taskforce Strategy 2016) and HM Government (2016a), helping people lead better lives as equal citizens through good parenting and school support during early years, decent housing and so on. Also, The College of Social Work (Allen 2014) identifies their agenda for social improvement and The British Psychological Society (Kinderman and Tai 2009), stating that mental health care is better located within a social, not a medical framework.

Mental Health Assessment: The nature and impact of childhood trauma needs to be more thoroughly considered in terms of mental health assessments. Currently there is limited

identification of childhood abuse history in psychiatry (Young et al. 2001). Indeed, Lothian and Read (2002) discovered that only 1 in 5 participants were asked about abuse history. They recommend that abuse history should be taken routinely in all mental health services. This may provide more accurate understanding of the influence of child abuse and assist in reducing its impact on hopelessness and cognitions. They discuss the need for policy to offer guidance on when and how to ask about abuse, how to respond to disclosures, provision of therapy and reporting crime (Lothian and Read 2002). In a DH (2003) report, violence and abuse was identified as a core issue for mental health and that staff should acknowledge the link between violence and mental health. Two important recommendations were cited, including, ensure staff raise issues of violence and abuse during assessment and reviews; and, provide appropriate care and support for survivors of abuse. Although the NHS Confederation (2008) arranged 15 mental health trust pilot sites to implement the policy, to date there has been no follow-up. The policy included inserting the 'abuse question' into assessment documentation:

"Have you experienced physical, sexual or emotional abuse at any time in your life?"

However, one major concern cited in the literature is the need for training to ask about abuse. For example, at present people with mental health problems are unlikely to receive an adequate response when they disclose abuse (Agar and Read 2002). Shevlin et al. (2012) believes mental health staff requires training in how to enquire and document trauma history in both childhood and adulthood. Although it may seem obvious that additional training and support is necessary (Longden et al. 2015), it perhaps explains the gap between policy and implementation. Recent guidelines from NHS confederation (2008), NICE Guidelines (2014), and HM Government (2015) all emphasise the need to routinely assess adversity exposure in psychiatric service-users. If training is a barrier, then training should be implemented as a priority.

Attachment-Based Strategies: The inclusion of attachment-based strategies is necessary in tackling the crippling social difficulties identified in this population. This can be achieved through a range of psychosocial interventions aimed at improving attachment experience and social presence. Indeed, enquiring about attachment style is straightforward and should be easy to implement using screening tools to explore social functioning, social competence and

relationships. As each attachment style presents a different challenge, identification assists tailoring any plan, formulation or pathway to the needs of the individual. Explicit attention can strengthen or adapt current attachment style (Schoore 2003).

Currently, two forms of approach help improve attachment experience. The first is a traditional therapeutic model incorporating specific challenges of working with attachment. For example, Pearlman and Courtois (2005) apply an attachment-relational approach to four issues, including forming a therapeutic alliance; maintaining boundaries; addressing past attachments; and managing dissociative processes. They believe attachment difficulties must be understood in the context of a therapeutic relationship beyond traditional psychiatric symptoms and skills deficit. As such, insecure attachment from childhood trauma requires treatment that addresses their developmental and relational difficulties (Pearlman and Courtois 2005). The second approach is newly formed models specific to attachment in individual or group therapy. For example, Mentalization-Based Therapy (MBT) as described by Bateman and Fonagy (2016) is widely recognised as beneficial for adults with psychiatric difficulties (Asen and Fonagy 2012) and children with insecure attachment (Midgley and Vrouva 2012). Bateman et al. (2007) state that MBT aims to: Promote mentalizing about oneself, others, and relationships. To do this, therapy is structured to enable a therapeutic alliance to adequately repair attachment ruptures. For service-user endorsement, see MIND (2015).

Enhance Personal and Social Resilience: There are three aspects identified here for improving resilience. The first is safeguarding children to prevent maltreatment and have a consummate and appropriate response when it is uncovered (WHO 2006). Preventing child maltreatment before it starts is possible if all relevant stakeholders adapt working practices and influence societal emphasis on child welfare (WHO 2016a). HM Government (2015) believe inter-agency working which includes health (NICE 2009), public services (NSPCC 2016a), schools (HM Government 2015a), police (HMIC 2015), housing (Shelter 2011) and prisons (HMI Prisons 2015), can protect children from maltreatment, prevent developmental impairment, ensure safe and effective care for the child and take action to enable best outcomes.

The second is intervention to support parenting, by improving capacity and reducing trauma. For example, Powell (2007) believes safeguarding is primarily accomplished through good

parenting. Positive support for good parenting should be the focus of all health and social professionals (Stern et al. 2008). As poor intergenerational attachment experience translates to children (Kwako et al. 2010) it is necessary to provide a secure base for parents (Lyons-Ruth et al. 2004: 84). This can be achieved through enhancing parental sensitivity to child (Kobak and Esposito 2004; Golding and Hughes 2012), help parental response to child (Juffer et al. 2003; Bakermans-Kranenburg et al. 2003), cognitive change through therapy (Cohen et al. 1999), enhanced social support (Gardner 2003) and improving maternal well-being (Howe 2005).

Finally, greater priority should be given to promoting 'social quality', referring to concepts of social inclusion, socio-economic security, social cohesion and empowerment (Beck et al. 1997; Putnam, 2001). Programmes found to improve social quality and wellbeing involves peer-to-peer education and support (Resnick and Rosenhan 2008). Such programmes already exist in the UK through local and national mental health charities, aimed at improving social cohesion and reducing the social determinants of poor health (Sheffield 2016; ABL Health 2016; Peabody 2016). For example, community work that supports the Well London Programme (2014) has been well-received. Evaluations identify improvements in understanding mental wellbeing, feeling positive, increased physical activity and healthy eating (Well London Programme 2014).

Summary

This study identifies survivors in the true sense. The devastating narratives are stark, graphic accounts of brutality and indifference from caregivers across the lifecourse. Experiencing such an assault on their personal being has taken a profound toll that is immeasurable. They remain detached, isolated, weary and untrusting of the social world. They also adapt self-perception to accommodate and tolerate such an insidious widespread abuse from all quarters. However, they remain resilient and present through their story of survival and defined by a history that continues to impact the mind, body and soul. Following the impact of a significant intimate, personal or social event, they reach a crisis point that leads to an immediate risk to self and the engagement of mental health intervention. Although this can further change their sense of self, they remain survivors.

Conclusion

The overall purpose of this research has been to investigate the lived experiences of childhood trauma amongst adults with mental health problems. The research questions were:

1. What was the nature of the childhood trauma experienced by participants?
2. What did participants consider to be the cause of their experiences of childhood trauma?
3. What coping and adaptation strategies (if any) did participants employ?
4. What impact (if any) did their experiences of childhood trauma have on their adult lives?

The specific aim was to understand these abusive experiences in terms of their various forms (nature), when and how they started (causes), the efforts made by survivors to protect themselves from such abuse (coping) and the long-term consequences into adulthood (impact).

This conclusion attempts to draw together and make sense of the most significant issues discussed throughout this thesis. It will be organised around three principal areas: section 1, considers the overall strengths and limitations of the research; section 2, discusses a number of ways in which the findings from this study may contribute to knowledge of the subject; section 3 suggests some future directions for research on childhood trauma and mental health.

Research Strengths and Limitations

In terms of the methodology, design and methods used in this research study, there are three important strengths that should be highlighted:

Firstly, in terms of methodology, traditionally, research on childhood trauma has been principally centred on the use of positivist methodology, employing quantitative data-gathering methods. This has been useful in uncovering particular risk predictors and patterns of abuse such as age of onset, perpetrators, duration and trauma type. One of the strengths of this study is the use of an interpretivist methodology employing qualitative methods. In particular, using a phenomenological approach has enabled the study of participant personal

lived experience of their childhood trauma and how this impacts on their psychological ability to cope and adapt to the social world around them.

Secondly, in terms of research design, through the use of IPA it has been possible to ensure that the participant is central to the research process and their voice given priority in the findings. This is an important strength of the research, given that people with mental health problems often hold a lower status and a powerless position in society. In addition, the experience of child abuse occurs in private spaces, hidden from public view and remaining a taboo subject in current society. Promoting the voice of lived experience through the pursuit of further understanding of the phenomenon attempts to change this, by enabling people with mental health problems and abuse history a voice. This voice represents their opportunity to reveal their unique personal experience, illuminated through the themes taken directly from their words. The majority believed that placing their story on record will assist others to tell their story and help make a difference to mental health service provision.

Finally, in terms of methods, the use of an informal, semi-structured (often in-depth) interview process has provided participants, who usually find social interaction and self-expression difficult, the opportunity to not only to talk about their experiences, but also reflect on their life and where they are now. Following the interview several participants reported that while at times raising such sensitive issues about their abuse experience was difficult, they nevertheless felt the whole process to be deeply cathartic.

Inevitably, however, often due to limited time, opportunities and resources, there will be a number of important limitations associated with undertaking such research. The key limitations with this study were:

Firstly, using self-report methods of retrospective information retrieval and sole researcher interpretations of the findings are important limitations to this study. In terms of the self-report approach, the present study relied on retrospective accounts of historical experiences. This is a contentious issue in the literature, with some believing the use of recall introduces potential response bias (Widom et al. 2004). Others even suggest recounting childhood events is subject to memory failure, distortion and revision of events, particularly in clinical populations (Alaggia 2010). However, Smith et al. (2009) takes the view that IPA is about

ascertaining phenomenological experience, not specific details. In phenomenological terms, experience is always consciousness of something, remembering is remembering of something; so there is an intentional relationship between the memory and awareness of it (Smith et al. 2009: 13).

With regards, to the issue of sole research interpretation of the findings, although several measures were taken to minimise researcher bias (see chapter 7), essentially the data was analysed by a sole data interpreter. This may create researcher bias, whereby, emerging themes are identified through a subjective expectancy that influences the findings of the study. It is preferable to have more than one researcher for inter-rater reliability. Data is interpreted independently and then compared in order to reach concordance of the findings. An emerging practice within IPA suggests going further and promotes the idea, where practical, of re-interviewing some participants and presenting researcher interpretation of their experiences. This provides participants with the opportunity to validate the interpretation of their comments and add more details where appropriate. Although an excellent form of data validation it was not deemed appropriate due to possible re-traumatising the participant. Instead, data was validated during several points of the interviewing process.

Secondly, sampling in this study has limitations through its sample size and homogeneity. For example, the sample size of fifteen participants is problematic for representativeness. This number is usual for health-related qualitative research (Dickson et al. 2007) and somewhat high for IPA (Smith and Osborn 2008); where between five-ten participants is typical for dedication to depth (Smith 2004). Such numbers have inherent limitations and cannot be considered representative of even the clinical population. As such, the findings cannot provide generalisations and any inferences are nominal. Although a limitation, it is not the aim of phenomenological research to create generalizable findings, but to gain an in-depth understanding of particular social and psychological phenomenon which in this case relates to the experiences of childhood trauma amongst adults who suffer from mental health problems.

In addition, although research designs such as IPA have a preference for homogenous samples due to a phenomenological focus (Smith et al. 2009) it means that such studies are defined within a setting. Therefore, any generalisations are limited to the localised population from

that setting (Robinson 2014). On the other hand, it should be noted that generalisability within phenomenological research comes through replication whereby a range of similar studies in terms of homogeneous populations and methodological approach start to reach similar interpretations of participant experience. This generalisability is identified through conducting meta-synthesis reviews of the qualitative research literature (Walsh and Downe 2005).

Finally, the third area of limitation is the lack of prior engagement with this vulnerable population to elicit trust and consult over the study design. For example, service user vulnerability may have been a barrier to inclusion in the study. Recruitment was based on voluntarily identifying as having been victimised, which may have excluded a number of potential participants unable to approach the unfamiliar researcher and vocalise their experience. This may suggest they are not representative of this population. However, some attempt was made to develop a sense of trust with potential participants during visits to organisations prior to the study, in order to discuss the research and provide reassurances to both organisation managers (who were trusted by their clients) and potential participants.

In addition, service users were not consulted directly in the development of the study design. Instead, service users were consulted on an informal basis regarding importance of the topic and ideas for construction of the interview guide, but not formally involved in contributing to study development. This is a limitation that may impact the research through reduced relevance and credibility (Thompson et al. 2009).

Research Contribution to Knowledge

The outcomes from this research contribute to understanding the association between childhood trauma and poor mental health during adulthood, in three important ways:

Firstly, this study found that participant experience of trauma was not represented as isolated incidents but typically widespread and multiple; interpreted as: pervasive, varied and continuous throughout their childhood. Findings show that all participants experienced child abuse, neglect and rejection through both direct and indirect violent interaction in the home environment. They also suffered restriction of all social activity outside the home, denying them any opportunity for social development, contribution or mobility. In addition, trauma

was not confined to the home, but also experienced as an insidious addition to a traumatic school life.

Secondly, the invasive violations described in the study distorted all childhood attachment relationships, creating dyadic interactions characterised by attachment insecurity and social mistrust which came to dominate all aspects of their personal and social world. The complete breakdown of attachments has a profoundly negative impact on the person and their lifetime ability to bond with another human being. This provides a significant understanding of the importance attachment relationships have in the negative trajectory towards mental health intervention, following childhood trauma.

Finally, the findings make it possible to develop the framework of a psychosocial model which may help explain why some people who are abused go on to suffer from mental health difficulties in adulthood. This model recognises the central role of insecure attachment but integrates this alongside other theoretical explanations, including cognitive deficit that impacts functional memory, learning and perception; generating a pervasive sense of hopelessness that there is no future, no alternative options and that nothing will change; a permanent psychosocial state of being which is softened only by a fragile form of protective resilience as they attempt to cope and adapt to adversity.

Future Directions

On the basis of the research evidence presented in this study there are a number of potential new directions for future research endeavours. Three important areas are:

Firstly, childhood trauma is pervasive and emerges as an endemic feature in all areas of participant life. Abuse and trauma appears to be instigated within the majority of relationship encounters and as such, forms a dynamic process that requires deeper understanding. To achieve this, future research could focus attention on investigating specific aspects of its insidious nature. As an example, it would be important to understand the occurrence of child abuse from multiple caregivers across childhood, including parents, siblings, extended family and teachers.

Secondly, the association between childhood trauma and insecure attachment is evident in the literature and recognised as a dominant factor in the present study. Other aspects are present, but it is a failure of attachment bonding in childhood that increases the possibility for lifelong dysfunctional relationships. Therefore, in-depth investigation of this association is important. For example, understanding which came first in the experience trajectory, child abuse or deactivated attachment system. If it is the former, then insecure attachment may be associated as a consequence of child abuse. If it is the latter, then this may suggest that abuse of the child is an extreme form of bonding failure. To achieve this, research could look closely at dyadic attachment relationships within families, especially between parent and child.

Finally, phenomenological lived experience reported in the study was interpreted as demonstrating a similar trajectory for the majority of participants. The resulting explanatory model (Figure 13.1) was developed to help illustrate the process and identify the psychosocial influence throughout. Testing aspects of the empirical viability of the model under certain circumstances would help determine the relative utility of such a model and where it might need to be refined or developed further. For example, in order to clarify the initial stage of the psychosocial model it would be important to investigate the combined presence of cognitive impairment and insecure attachment following the experience of childhood trauma.

A Final Remark

This study has helped elucidate understanding of childhood trauma and how it may impact the psychosocial wellbeing of adult survivors to the extent that they must endure a lifelong experience of poor mental health. This could only be achieved through the willingness of each participant to engage in the research process and share their personal, traumatic experience. It is hoped that their valuable contribution will start to make a difference.

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Adapted from Caldwell, Henshaw and Taylor’s (2005) Research Critique Framework.

This table assesses both qualitative and quantitative studies as per the framework; subsequent tables assess quantitative and qualitative studies separately using the identified framework.

Scoring: Are the criteria met (yes = 2 points); (Partially = 1 point) and (no or unclear = 0 points). Combination of both sets of scores to be a minimum of 18 points to be considered for inclusion in the review (18 criteria with a maximum score of 36, minimum score of 18 indicates 50% of criteria is met).

Article	Does the title reflect the content?	Are the authors credible?	Does the abstract summarize the key components?	Is the rationale for undertaking the research clearly outlined?	Is the literature review comprehensive and up-to-date?	Is the aim of the research clearly stated?	Are all ethical issues identified and addressed?	Is the methodology identified and justified?
Crawford et al.	2 2	2 2	2 2	2 2	1 2	2 2	2 2	2 2
Mayes et al.	2 2	2 2	2 2	2 2	1 1	2 2	2 2	2 2
Varcoe and Irwin	2 2	2 2	2 2	2 2	1 1	2 2	2 2	2 2
Kim and Gray	2 2	1 1	2 2	2 2	1 1	2 2	0 0	2 2
Moe	2 2	2 2	2 2	2 2	2 2	2 2	0 0	2 2
Green et al	2 2	2 2	2 2	2 2	1 2	2 2	2 2	2 2
Schilling	2 2	1 2	2 2	2 2	1 2	2 2	0 0	2 1
Bifulco	2 2	2 2	2 2	2 2	1 1	2 2	0 0	2 0
Alvarez	2 2	2 2	2 2	2 2	1 2	2 2	2 2	2 1
Macmillan	2 2	2 2	2 2	2 2	1 1	2 2	0 1	1 0

Appendix 1a: Kappa Rating

Qualitative Articles	Are the philosophical background and study design identified and the rationale for choice of design evident?	Are the major concepts identified?	Is the context of the study outlined?	Is the selection of participants described and the sampling method identified?	Is the method of data collection auditable?	Is the method of data analysis credible and confirmable?	Are the results presented in a way that is appropriate and clear?	Is the discussion comprehensive	Is the conclusion comprehensive	Are the results transferable?
Diane:										
Crawford	2 1	2 1	2 1	2 2	2 2	2 1	2 2	2 2	2 2	0 0
Mayes	2 1	2 1	2 2	2 1	2 1	2 2	2 2	2 2	2 2	0 0
Varcoe	2 1	2 1	2 1	2 2	2 2	2 2	2 2	2 2	2 2	0 0
Moe	2 2	2 2	2 2	2 2	2 2	2 2	2 2	2 2	2 2	0 0

Quantitative Articles	Is the study design clearly identified, and is the rationale for choice of design evident?	Is there an experimental hypothesis clearly stated? Are the key variables clearly defined?	Is the population identified?	Is the sample adequately described and reflective of the population?	Is the method of data collection valid and reliable?	Is the method of data analysis valid and reliable?	Are the results presented in a way that is appropriate and clear?	Is the discussion comprehensive	Is the conclusion comprehensive	Are the results generalizable?
Bob										
Kim and Gray	2 2	2 2	2 2	2 2	2 2	2 2	2 2	2 2	2 2	1 1
Green	2 2	1 0	2 2	2 2	2 2	2 2	2 2	1 2	1 1	2 0
Schilling	2 1	1 0	2 2	2 2	2 2	2 2	2 2	2 2	2 2	2 1
Bifulco	2 0	0 2	2 2	2 2	2 2	2 2	2 2	2 2	0 1	1 2
Alvarez	2 2	0 0	2 2	2 2	1 1	1 1	2 2	1 2	1 0	2 0
Macmillan	2 2	0 0	2 2	2 2	2 2	2 2	2 2	2 2	1 1	0 0

Example of calculation:

Paper 6:

	yes	no	total
yes	16	0	16
no	0	2	2
total	16	2	18

Expected agreement is:

$$16/18 \times 16/18 + 2/18 \times 2/18$$

$$0.7901 + 0.0123 = 0.8024 \text{ expected correlation}$$

Kappa coefficient is:

$$0.8888 - 0.8024 / 1 - 0.8024$$

$$.0864 / .1976 = K 0.4372$$

Therefore, the Kappa Statistic = 0.7140 (substantial agreement). From this exercise it can be concluded that all articles included are reliable in terms of quality.

Appendix 1a: Kappa Rating

Appendix 2a: Attachment Styles

The four-group attachment typology defined by Bartholomew and Horowitz (1991):

Within attachment literature the names ascribed are interchangeable. Therefore, all names are presented.

Secure or Autonomous

A secure attachment is formed when the caregiver provides a regular response that is protective, caring, and attentive to the infant's needs. The developing child is then able to use the attachment figure as both a 'secure base' and also a 'safe haven' when in danger or distress. The child learns that attachments are safe and trustworthy, defined through value of self, autonomy, comfort with intimacy and ease of emotional closeness. In Finzi et al. (2000) article, they discuss how secure children experience less fear in new situations, develop better problem solving abilities, show more cooperation in interpersonal relationships and more ego resiliency (Thompson 2000) and better cognitive performance (Jacobson et al. 1994). They also tend to have positive self regard and self care ethic that acknowledges their distress by seeking help (Feeney 2000).

Anxious-Ambivalent (Child) or Preoccupied (Adult)

An ambivalent attachment is formed when the caregiver's response is unpredictable. This creates hyper-activity in the child to switch from passive, angry, to preoccupied with the caregiver. The child's self is valuable only when certain conditions are met. They appear more 'needy' for attention; appear insecure and afraid and are resistant when directed away from their parents (Ainsworth et al. 1978). It is an attachment style defined by an overdependence and desire for extreme closeness that creates reluctance in others to get close. These children are withdrawn and vulnerable to threats of separation in social situations (Cassidy and Berlin 1994; Feeney 2000), synonymous with neglected children (Youngblade and Belsky 1990).

Although anxious-ambivalent people are highly dependent on others to maintain positive self-regard, they achieve this through a controlling interpersonal style that may be experienced as attempts to dominate the other (Bartholomew and Horowitz 1991). They blame themselves for perceived rejections and are overly vigilant to negative events (Feeney 2000), but maintain a positive view of others. A person with this style of attachment may be concerned about losing the relationship with any subsequent caregiver (Waldinger et al. 2006) and may strongly express their upset when this occurs (Feeney 2000).

Appendix 2a: Attachment Styles

Anxious-Resistant (Child) or Dismissing-Avoidant (Adult)

An avoidant attachment is formed when the caregiver is emotionally distant, physically withdrawn or controlling when the child is in distress. The child's attachment system becomes deactivated (indifferent and emotionally muted), and does not routinely seek connection with the caregiver. Others are unreliable and the child's self is unimportant to others. This promotes self-reliance and personal achievement; together with a devaluation of close relationships. The preference is not to rely on others or be relied on. It may lead the child to later express antisocial and aggressive behaviour in adolescence and adulthood (Finzi et al. 2000). In the dismissing style of adulthood, people downplay the importance of others whom they have experienced as rejecting to maintain high self-esteem within the model of self. With a distrust of others, they bring the expectation that they will not receive adequate attention or care from others, or be taken seriously by caregivers (Waldinger et al. 2006).

Fearful-Avoidant or Disorganised (Child) and Unresolved (Adult)

Some literature suggests unresolved state of mind can influence any of the attachment styles. Essentially, fearful-avoidant is formed in abusive and neglectful situations. The caregiver is experienced as frightening or regularly frightened and dissociated (usually due to abuse, addiction, being traumatised or depressed). The child is unpredictable and displays unusual behaviour. They are trapped between wanting the comfort of the caregiver and wanting to avoid the risk of danger. The child learns that others are dangerous and unreliable. The child's self is easily harmed in close connections with others.

Fearful-avoidance therefore involves distrust, fear of rejection or being hurt when close. Finzi et al. (2000) highlights research that suggests this style may lead the child to later exhibit emotional insulation and a lack of empathy. This style is associated with social insecurity and lack of assertiveness (Bartholomew and Horowitz 1991). A child who is abused or neglected by a needed caregiver is prone to develop an image of self as unworthy of support from others and an image of caregivers as unreliable and even dangerous (Waldinger et al 2006). Driven by fear of intimacy, people with this style of attachment avoid health-seeking behaviour by denying or suppressing any distress (Feeney 2000). These individuals are fragile, needy, and difficult to reassure, creating mutual misunderstanding, frustration and poor relationships (Waldinger et al. 2006).

Appendix 2b

Core Proposition of Attachment Theory in Adults:

- i. There is a basic impetus for the formation of attachment relationships provided by biological factors. Fraley and Shaver (2000) refer to the emotional and behavioural dynamics of child-caregiver relationships and adult relationships as being governed by the same biological system.
- ii. Experiences in earlier relationships create internal working models and attachment styles that systematically affects all attachment relationships. In consideration of the child's environmental influence,
- iii. The attachment orientation of adult caregivers influences the subsequent attachment bond their children will have with them.
- iv. Working models and attachment orientations are relatively stable over time; but not impervious to change.
- v. Some forms of psychological maladjustment and clinical disorders are attributable in part to the effects of insecure working models and attachment styles.

Rholes, W.S. and Simpson, J.A. (2004) *Adult attachment: Theory, research, and clinical implications*. New York: The Guilford Press.

Have you experienced childhood victimisation?

Would you be willing to discuss your experiences as part of a strictly confidential research study?

My name is Robert Tummey and I am currently studying at Coventry University. As part of my studies I am completing a research project looking at childhood victimisation of individuals with mental health problems.

I am looking for individuals with mental health problems who have experienced childhood victimisation, including being bullied, threatened or hurt by other people including:

- being called names,
- people pushing or touching you,
- people hurting you,
- people stealing from you.

All my research is strictly confidential and will require a face-to-face, private, tape-recorded interview that lasts about an hour. We will discuss your experience, why you think you have experienced such things, how it has affected you and, your views on how to stop it happening again.

Why is this information important?

I believe we need a greater understanding of the experiences people are having with regards to being hurt or bullied. With understanding we may be able to help put a stop to such experiences.

Once we have completed the interview, I have written up what you said, I will complete a report based on the information I received. I will provide you with a summary of my findings and also disseminate the findings via your local mental health charity and appropriate health press.

If I would like to take part in the research project:

Then please call me on the number below and leave a message if I am unable to take your call. Also, email if this is more convenient. Once agreed, we will meet, complete consent forms and commence the taped interview. You can withdraw from the study at any point. Please feel free to ask me any questions.

How do I contact you?

Content removed due to data protection considerations

Appendix 5b: Participant Information Sheet

Research Study: **Experiences of Childhood Victimization** **Amongst People with Mental Health Problems**

My name is Robert Tummey and I am currently studying at Coventry University. As part of my studies I am completing a research project. I have chosen to look at childhood victimisation and would like to invite you to take part. Before you make a decision please read the information below. Please, feel free to ask me any questions about the research.

The Research Project

The aim of the research project is to gain the views of people with mental health problems who have experienced childhood victimisation. I would like to hear about your experiences of being bullied, threatened or hurt by other people. Things you may have experienced include:

- being called names,
- people pushing or touching you,
- people hurting you,
- people stealing from you.

I would like to ask you about what you have experienced, why you think you have experienced such things, how it has affected you and, your views on how to stop it happening again.

If you agree to take part in the project we will meet for a private interview that lasts about one hour and I will ask questions about your experiences of childhood victimisation. All information we discuss will be treated confidentially and secured in a locked cabinet in a locked office.

If it is ok, I will need to tape-record the interview. I will not tell anyone what you said and will delete the tape recording once I have it written down.

The experiences we discuss will have already been reported to family or the authorities/Police. If we talk about experiences which are crimes that have not been reported we will need to report the experience to the Police. This would be with the support of your local Mental Health Charity. Participation will not have any impact on disability living allowance or health treatments.

Why is this information important?

I believe we need a greater understanding of the experiences people are having with regards to being hurt or bullied. With understanding we may be able to help put a stop to such experiences.

Once we have completed the interview, I have written up what you said, I will complete a report based on the information I received. I will provide you with a summary of my findings and also disseminate the findings via your local mental health charity and appropriate health press.

If I would like to take part in the research project:

Then please call me on the number below and leave a message if I am unable to take your call. Also, email if this is more convenient. Once agreed, we will meet, complete consent forms and commence the taped interview. You can withdraw from the study at any point. Please feel free to ask me any questions.

How do I contact you?

Feel free to contact Robert Tummey:

Content removed due to data protection considerations

Research Study:
Experiences of Childhood Victimization
Amongst People with Mental Health Problems

Dear Participant,

Please tick the boxes below and sign your name at the bottom of the page if you are willing to take part in the above research project.

1. The study has been explained to me and I understood the information. I have had the opportunity to think about the information and to ask questions.	
2. I understand that taking part is entirely voluntary and that I am free to change my mind and withdraw at any time, without giving any reason.	
3. I agree to being interviewed and the interview being tape recorded.	
4. I have the right to refuse to answer any question and can terminate the interview at any time.	
5. I agree that (anonymous) quotes from my interview may be used in the write up of the study and may be published.	
6. I would like to receive a summary of the results.	
7. I agree to take part in this study.	

I give my consent to sharing information about victimisation and this information being used as part of a research study.

Participant Name:..... Signature:.....

Researcher Name: Robert Tummey Signature:.....

Content removed due to data protection considerations

Research Project:
Experiences of Childhood Victimisation
Amongst People with Mental Health Problems

Thank you for being part of my research study. You have been most helpful and will contribute to the knowledge and understanding of this topic.

This completes your involvement in the study. Thank you once again for your participation. Once I have collated the information I will provide you with a summary report of the findings.

If you experience any concerns as a result of the information we have discussed, please contact one of the organisations below:

1. Coventry and Warwickshire MIND - 02476 552847
2. MIND Mental Health Charity
<http://www.mind.org.uk/help/crisis> - Crisis Advice.
3. Coventry Victim Support: 024 7683 9950
4. Victim Support: 0845 30 30 900
<http://www.victimsupport.org/Contact%20us>
5. Coventry Citizens Advice Bureau: 024 76 252052
<http://www.coventrycab.org.uk/> - Coventry CAB.
<http://www.citizensadvice.org.uk/> - National CAB.
6. Samaritans 08457 90 90 90

How do I contact you?

Content removed due to data protection considerations

Appendix 5e: Participant Pen Portraits

THE PARTICIPANTS

PEN PORTRAITS

The significance of the participants' contributions is warranted in any research. However, in the tradition of IPA, it is important to recognise the individual, ideographic commitment to the particular case within the homogenous group. To this end, individual pen portraits will introduce each of the participants and help contextualise their input into the study. The pen portrait is a brief 'sketch' of the individual, using a pseudonym to protect their identity.

ISLA

Isla is a 58 year old woman who lives alone in a local housing association flat. Isla has been employed throughout her life but will not be returning to work following the breakup of her marriage. She is currently receiving disability benefits. Isla is single, but has been married twice and has six children from her first marriage. At the moment she is awaiting a divorce from her second husband. She has both mental and physical health problems. She engages with the local mental health charity for support via drop-in attendance and group work. Isla experienced childhood trauma with both parents dying whilst she was a young child.

Interview: Reasonably quickly she appeared relaxed and sat back in her chair. She seemed comfortable but kept her coat on throughout the interview. We had a good rapport. When talking about her Mother she'd become tearful and drop her head into her chest. She talked of the loss she experienced when her mother died, and continues to feel... The interview experience was emotional.

"...it just seems like from the time I was young I've been on me own really..." [P:18. L:5].

Interview Date: 11/04/2012. Total Time: 85 minutes

JACOB

Jacob is a 62 year old man. He lives alone in a local housing association flat. Jacob is single and has never married, although came close. He has always had employment but is now retired on health grounds. Jacob suffers both mental and physical health problems. Jacob experienced childhood trauma through two extended periods in hospital as an infant and the death of his Mother when he was fifteen years old.

Interview: He appeared relaxed throughout the interview. We seemingly had a good rapport, with Jacob showing good eye contact and smiling at times. It felt like the interview was led by Jacob. At times though it felt like a clinical interview. I was very conscious of this and did not want to probe or follow this line of inquiry. I attempted to allow the interview to take its course but re-focus on victimisation and not clinical content without being explicit.

"I was directed to attend a [Mental Health] day centre. I looked around and thought, 'this is not for me.... I am not like these.....' But I am..." [P:37. L:10].

Interview Date: 12/04/2012. Total Time: 99 minutes

AMELIA

Amelia is a 43 year old woman who lives in a housing association three-bedroom terrace house. She has three grown up children, the eldest of whom is 27 years old. Amelia divorced seventeen years ago and has not been in a relationship since. She left school with no qualifications and has had no employment. Currently she receives disability benefits and attends the local mental health charity on a daily basis. She is also involved in mental health training. Amelia has had various mental health problems and significant physical health problems too. Her experience of childhood trauma involved familial sexual, physical and emotional abuse.

Interview: Amelia folded her arms from the start of the interview and periodically throughout. She maintained good eye contact until talking about her experience of child abuse. She held a takeaway coffee cup to the centre of her chest and at times stared upper left at the wall as though in a trance (visual construct in Bandler and Grinder 1979 eye access cue chart). Other times during the interview Amelia recounted events in a matter of fact way, seemingly detached from the emotion of the topic.

"I think a lot is circumstance... You can't control who your family is... and I think that when bad things happen... it impacts your soul and it affects how you respond...errr, and how you interact... I mean, often... mental health... that has impact...from trauma as a child.....errr,..... I mean I don't know....and don't really understand... you know, how it alters your thinking and what have you...but, I suppose it has to..... So, I think it impacts your soul and that impacts how you react and respond to people around you..." [P:39. L:23].

Interview Date: 23/04/2012. Total Time: 120 minutes

AVA

Ava is a 47 year old woman who is divorced. She is the mother of three children who currently lives alone in the three-bedroom family home. Her children have left home. Ava attained a masters degree level education and has worked in a position of authority until recently. She is currently unemployed and receiving disability benefits due to mental health problems. Ava's experience of childhood trauma involved paternal sexual abuse and peer victimisation at school.

Interview: Animated with use of hands to talk, but very limited eye contact throughout. Ava was awkward in self (shaking) visibly anxious. No eye contact when discussing childhood and

found it difficult to talk about sexual abuse. I let Ava explain, but this resulted in limited information. She smiled when talking about her parent's selfishness. She was bullied as a child and feels she continues to be bullied into adulthood. By the end of the interview, Ava was more animated and gave more eye contact.

"Errm, and then I was abused by my Dad and so, I think that's why I ended up being very errm, together... do you know what I mean.. On my own... and stuff... and not needing anyone... but also having to be responsible quite a lot of the time... errm, or feeling I had to be responsible." [P:12. L:1].

Interview Date: 13/04/2012. Total Time: 120 minutes

POPPY

Ava is a 47 year old woman. She is a widower who lives alone in a local housing association bedsit. Ava left school with no qualifications and has had limited employment throughout her life. Currently she attends the local mental health charity drop-in centre and various classes on a daily basis. She has been known to mental health services since her early twenties. Ava had experience of childhood trauma through sibling sexual and emotional abuse.

Interview: Throughout the interview Ava was open and comfortable to talk about her experiences. She answered each question and was engaged and engaging throughout. She was friendly and seemingly quite happy. We had to complete the interview slightly early as the centre was closing. We agreed to meet again, but did not have the same rapport at the second shorter meeting.

"Well to be honest, I don't think I was treated very fairly, because well... fair enough... my brothers were put into care for what they did to me but then it only left me and my sister... and it felt as though she (Mother) was treating my sister more better than me... Like, my sister was getting all the love and attention... than I was." [P:19. L:13].

Interview Date: 13/04/2012. Total Time: 95 minutes

OSCAR

Oscar is a 47 year old man who lives locally in a housing association bedsit. He left school with no qualifications and has had intermittent unskilled employment throughout his life. Currently he receives disability benefits. Oscar is single, but has an estranged partner with whom he has a teenage son. His mental health problems have been a factor throughout his adult life. The childhood trauma he experienced included parental neglect, and both physical and emotional abuse.

Interview: It was difficult to understand what he said. His voice was somewhat muffled. He sat with his arms folded throughout. There were visible tears streaming down his face when he talked of his childhood. He was tiring during the interview at times. As the interview progressed he placed his sunglasses from the top of his head to his eyes. At the end he mentioned crying and that if he hadn't cried he would have shouted or 'got' aggressive. He preferred to share the information and weep.

"...tried to change the past... I'll stop dwelling on the past... I keep having the past in my head all of the time... I can't go forward... I try to go forward... but I'm worried about the past all of the time... the past, the past, the past... It's doing my fucking head in... I can't go forward..."
[P:21. L:24].

Interview date: 18/04/2012. Total Time 80 minutes

SOPHIA

Sophia is 51 year old woman who lives alone in her own three-bedroom house. She completed her schooling but has had limited employment opportunities as a result of her mental health problems. Sophia currently receives disability benefits. She is single and has never married, but has an adult son from a previous relationship. Their relationship is estranged. Sophia attends the local mental health charity on most days. Her experience of childhood trauma involves familial physical and emotional abuse and also, peer and institutional sexual abuse.

Interview: Sophia engaged well in the interview and offered excellent interactive communication skills, such as posture, eye contact and conversation. On occasion she would look over at the Dictaphone purposefully. She talked well and openly discussed issues. At times she used colloquial sayings and expressions from Northern England. I understood them but sought clarification for the recording. I also sought further clarification of answers if I thought I may misunderstand due to her accent.

"...when I've had difficult situations... people have been very abusive to me... I find that incredibly difficult to deal with on my own.... It opens up the past, you know like, past memories and that... nightmares and stuff... I don't know...I think through loneliness I get involved with the wrong people...or something... I'm just glad for people to be my friends and maybe they're not suitable people to be my friends but you're kind of limited when you're not working..."
[P:30. L:18].

Interview Date: 09/05/2012. Total Time: 140 minutes

WILLIAM

William is a 51 year old man who lives in a local housing association flat. He left school with no qualifications and has not had any employment since early adulthood. William is single and has

never married. He has one adolescent son from a previous relationship. He is receiving disability benefits due to his mental health problems. William attends the local mental health charity on a regular weekly basis. His experience of childhood trauma involved familial physical abuse and domestic abuse.

Interview: William was rather intense in the interaction. His eye-contact was piercing at times. He was animated and loud throughout and anxious to share his point. He had a number of letters on his person, that relate to his experiences of victimisation. The intensity made it hard to remain focused at times. He asked if I would like copies of his letters, but I respectfully declined due to confidentiality and unnecessary.

"...We are... we are the black sheep of the family... once you're mentally ill." [P:28. L:6].

Interview Date: 14/05/2012. Total Time: 105 minutes

JAMES

James is a 61 year old man who is wheelchair bound and lives alone in a housing association flat. He attained a degree level education and worked for many years during young adulthood. James is single and has never been married. He has both mental and physical health problems and attends the local mental health charity on a weekly basis. The information James shared about childhood was limited, but he did mention his parent's divorce as a traumatic childhood period.

Interview: James remained on his mobility scooter throughout. At times it was difficult to talk. He wanted to know, 'Ok, What's next?' This interrupted the flow on occasion. His tone of voice was sometimes stern. It was hard to 'read' him. He would joke, but unclear if he was being serious, as though playing a game I was unsure of... He seemed somewhat dismissive, blowing his nose, distracting, diverting attention and so on... James needed much reassurance about confidentiality with recording his voice and matching it to his name, voice and data. I assured him it would be confidential and that he could withdraw his information at any time.

"...The thing is, years ago I wanted to get married and have kids... Now whether it will happen... whether it does or it doesn't happen I don't know... If it did it did, if it don't, it don't...But... that's what I wanted but we all have our pperrrrr... goals what we want..." [P:32. L:27].

Interview Date: 17/05/2012. Total Time: 78 minutes

NOAH

Noah is a 62 year old man. He lives in a local warden-controlled flat. Noah left school with no qualifications. He worked for most of his young adulthood until he retired on health grounds, related to mental health problems. He receives a pension. Noah is single and has never had a

long-term relationship. He suffers with both mental and physical health problems and attends a local mental health charity daily. He experienced childhood trauma through parental neglect and domestic abuse and peer victimisation.

Interview: Particularly challenging to understand what Noah said. There was limited eye contact throughout. He was eager to leave after 45 minutes in order to receive his pudding. Quite a bit of information was offered but I did get the impression some was being withheld. At times he was quiet and seemingly in thought with some topics. Interview was completed but really, ended rushed due to wanting a pudding. I felt there was no benefit in arranging another meeting.

"...I was bullied... Yes, in the playground... By the school kids..." [P:23. L:27].

Interview Date: 23/05/2012. Total Time: 59 minutes

EVIE

Evie is a 58 year old woman who lives alone in the three-bedroom family home. She is a mother of two children. Evie divorced ten years ago and has not had a relationship since. She has not worked for many years and currently volunteers and receives disability benefits. Evie has had mental health problems since early adulthood. Her experience of childhood trauma was mother's disability and long-term depression.

Interview: Evie was wearing glasses and dressed in colourful summer clothes. Before we commenced the interview, she mentioned several things as I prepared the room. May cry, Wants to talk, Will this remain confidential? There seemed to be an issue of trust. It was rather difficult to gain information initially and in particular about childhood. Evie was very softly spoken throughout the interview.

"Errrrm..... I know a lot of this is all fragmented 'cause a lot of it I blocked out... so it all seems like it's coming back to me... Episodes are coming back and certain things..." [P:27. L:25].

Interview Date: 14/06/2012 Total Time: 115 minutes

ELLA

Ella is a 42 year old woman who lives in a housing association flat. She is single and has never had a relationship. Ella attained a degree level education. Although suffered mental health problems at the time of attending university, she returned to complete her degree in later adulthood. She has not worked but does volunteer for the local mental health charity. Ella currently receives disability benefits due to both mental and physical health problems. Ella experienced childhood trauma through familial sexual and physical abuse.

Interview: Ella was sat comfortably throughout and maintained good eye contact unless talking about abuse. She wore glasses and was drinking coffee. When talking, she would use a 'matter-of-fact' tone, with no emotional connection. She seemed detached from the information she shared, or didn't feel she'd be believed. She talked about ritualistic abuse from a very early age.

"So..... I was born into a family... that was very....steeped in abuse and it was still going on... and... that wasn't really anyone's fault whether I was born into that family...it was.... Even if it was their fault as adults they were abusing people... and the effects of the abuse.... have led to mental health issues..." [P:32. L:21].

Interview Date: 06/07/2012 Total Time: 100 minutes

SCARLETT

Scarlett is a 22 year old woman who lives in a shared house. She is single and has not had a relationship for three years. Scarlett is currently a student at university. She has suffered with mental health problems since the age of fourteen. Scarlett experienced childhood trauma through parental physical and emotional abuse and peer victimisation.

Interview: Scarlett sat facing away. She looked down to the left throughout the interview (auditory-internal dialogue in Bandler and Grinder 1979 eye access cue chart) and limited eye-contact. During the conversation, Scarlett would finish each sentence and then drift away, seemingly 'somewhere else'. She would not speak spontaneously or offer information voluntarily. When talking about her sisters, I detected a fondness in her voice. Scarlett was mainly preoccupied with recent events. She may lose her place at university due to poor attendance.

"I hated school. I haven't got a nice memory of school and I wouldn't go back there if someone paid me to go back... (pause) ...It was just horrible. I absolutely hated school. I hated the teachers and I hated the other students." [P:12. L:16].

Interview Date: 06/07/2012 Total Time: 65 minutes

ISABELLE

Isabelle is a 48 year old woman who lives in a housing association flat with her husband. She works in a caring profession having completed her training in early adulthood. Isabelle grew up on a farm with a strong work ethic. She has experienced mental health problems throughout her adult life. During her childhood she was emotionally abused and controlled by her father.

Interview: Isabelle was quite masculine, wearing a flat cap, fleece and jeans, with short hair. She sat with legs apart. Isabelle appeared relaxed and engaged with good eye-contact. I

noticed that when she talked of her childhood, she seemed to use a childlike voice. We seemed to share a good rapport and the interview flowed well. On completion Isabelle thanked me genuinely for being able to talk through her experiences and hoped the material would be helpful to my study.

“Very few... (Childhood friends) I was very much a loner... Very much did things on my own... Some just wouldn't bother to talk to me anyway... (spoken quietly). I didn't... I don't.... make friends easily... Errm, I never have done...” [P:39. L:6].

Interview Date: 18/07/2012 Total Time: 110 minutes

FREDDIE

Freddie is 37 year old man who lives in a housing association shared house. He has attained a degree level education and has worked in various jobs throughout his adult life. Freddie receives disability benefits, but does volunteer for the local mental health charity. He is currently single and has not had a relationship since breaking up with his fiancé three years ago. Freddie experienced childhood trauma through paternal physical and emotional abuse and peer victimisation.

Interview: Freddie arrived 5 minutes late. He seemed a little flustered but was ready to begin the interview. When talking about his childhood, Freddie became visibly uncomfortable and somewhat detached. He minimised eye contact, favouring to pick a spot on the wall, high and to the right (visual recall in Bandler and Grinder 1979 eye access cue chart).. There were long pauses throughout the interview due to being thoughtful in his answers.

“Harrf, Ohhhh, I was always the incredibly short, shy kid with the silly curly hair and the incredibly poor background... So... I always did a lot of work academically, always very shy, so I was bullied intensely... Mmm... Huh huh... pretty much... pretty much on a daily basis...” [P:17. L;11].

Interview Date: 23/07/2012 Total Time: 110 minutes

SUMMARY

Each participant has been detailed here with a brief sketch of their background story, an insight into experience of them at interview and an illustrative quote from their words in the interview.

Childhood Victimisation Interview Guide

for People with

Mental Health Problems

The aims of this research project are to discover:

1. What is the nature of childhood trauma for people with mental health problems?
2. What are the causes of childhood trauma?
3. What preventative strategies are employed?
4. What impact does childhood trauma have?

Robert Tummey

Ph.D. Student.

PART ONE: BACKGROUND CONTEXT

Interviewer comment: Our discussion will start by asking you a few questions about you in general such as your age and general state of health.

01) Please tell me about yourself?

Socio-demographics:

Age:

Gender:

Marital Status ... history

Ethnicity/Race:

Religion:

Partner/Marriage/Sexual orientation:

Schooling ... history/qualifications

What type of house do you live in? What is the area like?

What do you do during the day ... work history/how long?

Physical health:

Use a wheelchair

Have difficulty walking

Are blind or visually impaired

Are deaf or hard of hearing

Have speech difficulties

Have less obvious difficulties (autism, diabetes, epilepsy, anorexia)

Have long-term illness or health condition (cancer, HIV, heart disease)

Other difficulties, please specify

How often did you spend time in hospital/care due to these difficulties?

Mental health:

Do you have a psychiatric diagnosis? History

What are the key symptoms/problems you have experienced? History

When was the worst time for you? What happened?

How often have you spent time in hospital due to these difficulties?

01a) What do you most like spending time doing?

Spending time going out socialising with my family, and or friends, and or new people

Spending time at the day centre/place of work

Spending time at home on my own, or with family, or with friends

What are your favourite hobbies/interests – things that you like to do the most?

01b) What was your childhood like?

Generally happy or unhappy childhood

Relationship with your parents/siblings. How did you get on?

Traumas (death, divorce, separation, domestic violence, abuse)

Were your parents always married? Did they argue?

How were you treated as a child? Cared for, Punished, Given encouragement

01c) What were things like for you at school?

School level – primary/secondary/college/special school?

Did you have many friends?

Did you ever get into fights? Why?

Did other children pick on you, you pick on them? Why?

Would you say that you were bullied – history (frequency, nature, etc)

PART TWO: EXPERIENCES OF VICTIMISATION

02) What has been your experience of victimisation?

How frequent?
Almost every day
At least once or twice a week
At least once or twice a month
At least once or twice during the past

02a) Can you recall the worst time in which you were frightened or hurt? What happened?

For each incident, use the following markers:

Relate first to the **general**, then **specific** incident and then more **general**:

Form: Saying nasty things about you (verbal abuse, phone calls)
Writing nasty things about you (letters, texts, graffiti)
Spitting at you; throwing things at you
Repeatedly picking on you/pestering you (harassment)
Threatening to hurt you;
Physically hurting you (hitting, kicking, pushing)
Making unwelcome sexual advances (touching, pestering, rude comments)
Stealing something from you: (money, property)
Damaged something of yours (property, home, garden, car)

Who: Relative/family member – partner, friend, neighbour, carer, stranger
Children – teenager – adult
Male – female
Group of people or individual
Other person with mental health problems
Have others experienced similar

Where: Private space (your home, garden, other person's home)
Public space (park, street, shopping centre)
Public premises (pub, cafe, place of work, day centre)
Public transport (bus, train, taxi)

Time: Morning, afternoon, evening

PART THREE: CAUSES OF VICTIMISATION

03) Why do you think these things happened to you?

Situational factors:

Where I live – unsafe neighbourhood
People I hang around with
Places I go
Things I get involved in

Social factors:

The amount I drink
The drugs scene I belong to
My involvement in crime

Personal factors:

Mental health
Other disability
My religion / sexuality
My attitude / own stupid fault / just bad luck
Other, please specify

PART FOUR: PREVENTION OF VICTIMISATION

04) How do you protect yourself? Self prevention:

Move house	Avoid talking to people who hurt/frighten me
Change jobs	Avoid going out at certain times of the day
Changed phone number	Stopped going out
Do you avoid going to certain places	Other solution, please specify
Carry a weapon or personal alarm	

Did it work, if no, what happened?

04a) Have outside agencies helped? Formal prevention:

Police, MH services, GP services
Took down details, but took no further action
Stopped the person from hurting me
Told me they could do nothing
Were you happy with the police response?

If no, why were incidents not reported?

Have you told anyone else about this/these incidents?

Relative/family member	Neighbour
Friend	Carer or other professional

If no, why haven't you told anyone else about this/these incidents?

It was not important enough to tell anyone
I have a relationship with person who hurt/frightened me
No confidence that anyone can help
Embarrassed
Difficult to explain what happened
It is just part of 'everyday' life
It happens too often to report
Don't want to be a bother to people
No one can really help stop it

PART FIVE: IMPACT OF VICTIMISATION

Expression: What words/phrases best describe how you felt after this happened?

Upset, angry, unhappy, sad, terrified, frightened, devastated,
Shocked, the worst day of my life,

05) What is your quality of life like at the moment?

Your comforts (housing, food, clothes, heat, etc)
The neighbourhood community in which you live
Your physical health
Your relationships with family (immediate and extended)
Your friendships – how do you get on with people? What about those you don't get on with?
The level of community mental health support you receive
Your social life (clubs you belong to and activities involved in)
Your opportunities for leisure activities or hobbies
The way other people treat/respect/behave towards you
With life in general

05a) How do you feel about your future?

Content removed due to data protection considerations

Initial Noting: Participant PPS1F		
Emergent Theme	Original Transcript	Exploratory Comments
	Content removed due to data protection considerations	<p>Experience and <u>Perception</u>?</p> <p>Negative influence Difference</p> <p>Reaction to experience of victimisation</p> <p>Coping strategy. <u>Challenge</u>? Determination</p> <p>Support. Belief</p> <p>Encouragement. <u>Maternal role of friend</u>?</p> <p>Belief Recognition of knowledge and experience</p> <p><u>Positive Identity. Progression</u></p>

	<p>Content removed due to data protection considerations</p>	<p>Contrast. Abuse of position. Personal attack. Psychological abuse. Rejection.</p> <p>Growth of self. Again, identity is important <i>Language used is interesting: re-invent...</i></p> <p>External Labels = <u>Personal identity issues?</u></p> <p>A range of diagnoses. Seems at whim of psychiatry. Lack of clarification – poor service/support.</p> <p>Adolescent mental health problems</p> <p>Lack of clarity/support.</p> <p><u>Vulnerability?</u></p>
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Developing Emergent Themes: Participant PPS1F

Emergent Theme	Original Transcript	Exploratory Comments
<p>Victimisation</p> <p>Almost a protective reaction</p> <p>Protective</p> <p>Victimisation</p>	<p>Content removed due to data protection considerations</p>	<p>Experience and <u>Perception?</u></p> <p>Negative influence Difference</p> <p>Reaction to experience of victimisation</p> <p>Coping strategy. <u>Challenge?</u> Determination</p> <p>Support. Belief</p> <p>Encouragement. <u>Maternal role of friend?</u></p> <p>Belief Recognition of knowledge and experience</p> <p><u>Positive Identity. Progression</u></p> <p>Contrast. Abuse of position. Personal attack. Psychological abuse. Rejection.</p>

Appendix 7c: Example of Colour Coding

Content removed due to data protection considerations

Colour Code:

Orange = Victimization

Blue = Health

Yellow = Preventative

Red = Impact

Green = Context

Appendix 7d: Initial Themes: Parental

Parental

Mother: Domineering

Pg 33:

PPS12: Because my brother was very awkward you know..he used to go out a lot playing football. I was there and **she'd (Mum) make sure I was there..you know, to help with my sister..** and errm, so yeah....

Pg 35:

PPS12: I felt that in a way my Mum... **she was very domineering you know...**and she **wouldn't like give you choices** much you know, she'd let you choose but then she'd change it...ha ha ha (laugh) and it was **what she said went** you know...

Pg 35:

PPS12: **I felt like very... dominated by my Mother and she tried to control everything**, you know, from my friends to my play, you know my brother could stay out for ages... Or she'd forget and **I'd get told off coming home from school late**, you know if I wanted to youth club... she'd try to put me off going to it..

Emotional abuse

Pg 34:

PPS12: **...she used to start picking on me then you know.....taking it out on me and belittling me...**

Int: In what way?

PPS12: Well she's just very errrm, **condescending and rude to me**, you know and start **picking faults with me** and stuff.. **nothing is ever good enough**, you know.. So that **didn't do much for my confidence...**Errm, she wasn't errrm, I think **she was very stressed and I think she was kind of depressed...** you know like, bringing my sister up...

Pg 35:

PPS12: ...She didn't beat me up or anything like that, but I think **she was a bit cruel sometimes...very cruel...** Very.....**always like criticising**, you know what I mean..? Or what they call the **over-critical parent** ha ha ha (laugh)...

Physical Abuse

Pg 35:

PPS12: That's all I can say about it really...**she did hit me quite a bit sometimes...**

Int: Hit you?

PPS12: Yeah... but I think parents did in them days, **they used to smack kids** and stuff.. until she went over the top...

Pg 40:

PPS12: **She tried to strangle me once**.... I think it was when I was really depressed and she was really fed up... you know, exasperated and she was just **testing out what my reaction** was...and **she put this chain or something**... I don't know if it was a **chain or something around my neck**, to try to **strangle me**... I think she wanted to **see if I'd fight for my life** or something...you know... really weird...

Pg 41:

Int: What was punishment like as a child...?

PPS12: **Well I'd get slapped... quite hard**... or it'd be like, 'wait until your Father gets home'..

Int: Right.... So, was it Mum or Dad who punished..?

PPS12: **Mum slapped me**... my Dad didn't... I don't ever remember my Dad slapping me at all...

(noise of people acknowledging each other outside the room)..

But my Mum would slap me...

Domestic Violence

Pg 40:

PPS12: They (parents) **used to argue sometimes and sometimes have violent fights**.. errrm, shouting.... My Mum would get exasperated...stressed out and start shouting.. **Once she cut me and once she cut my Dad**. I think she threw something and allof **his elbow got cut** you know...and.... **I got cut on my hand**...'cause she was **waving this knife** about when she was angry one day..I put my hand up to protect me and you know, it sliced my hand...

Pg 40:

PPS12: ...My **Dad would have fights with my brother**...if my brother had been very unruly... **they'd end up fighting** and my Dad would end up trying to pin him down.. which wasn't very pleasant..but it didn't happen all of the time... But it's quite vivid isn't it when you see stuff, you know in your imagination, when you see it in your mind...

Int: Mmm

PPS12: Vivid in your mind, you know when you see a lot of stuff going on... so the **tensions came out aggressively** sometimes...

Int: Mmm

PPS12: Yeah... So.... it wasn't very stable in a way...**It wasn't a very stable childhood**, you know...

Appendix 7e: Connections across Emergent Themes

Two distinct spectrums: Childhood vs Adulthood

Three major thematic Sections: Context, Impact, Reaction.

Subordinate Themes for each section:

Combined Context:

Family (Inc: Parental, Children, Siblings, Partner)

= *Emotional Abuse, Neglect, Sexual Abuse, Detachment, Physical Threat, Rejection, Physical Abuse.*

Peers (Inc: School children, friends, contemporaries)

= *Physical Abuse, Emotional Abuse, Rejection.*

Neighbours (Inc: childhood and adulthood)

= *Sexual Abuse, Emotional Abuse, Crime.*

Institutional (Inc: School, Housing, Courts, MH Services)

= *Physical Abuse, Emotional Abuse, Negligence, Secure Unit, Poly-Pharmacy, Attitude, MHA.*

Strangers

= *Crime.*

Combined Impact:

= *Fear, Avoidance, Perception, Vulnerability, Health, Repeated History.*

Combined Reaction:

= *Resilience, Protection, Compliance, Physical, Suicide.*

Vulnerability: - Isolation, Target, Fear, Financial Abuse, Emotional Abuse, Physical Abuse, Oppression.

Life chances: - Family, Poverty, Expectation, Education-poor, Support, Multiple Abuse, Circumstance.

Lack of Self-Determination: - Locus of control, External control, Age, Discrimination, Status.

Lack of Validation: - Rejection, Poor bonding/relationships, Lack of belief/justice, Harassment.

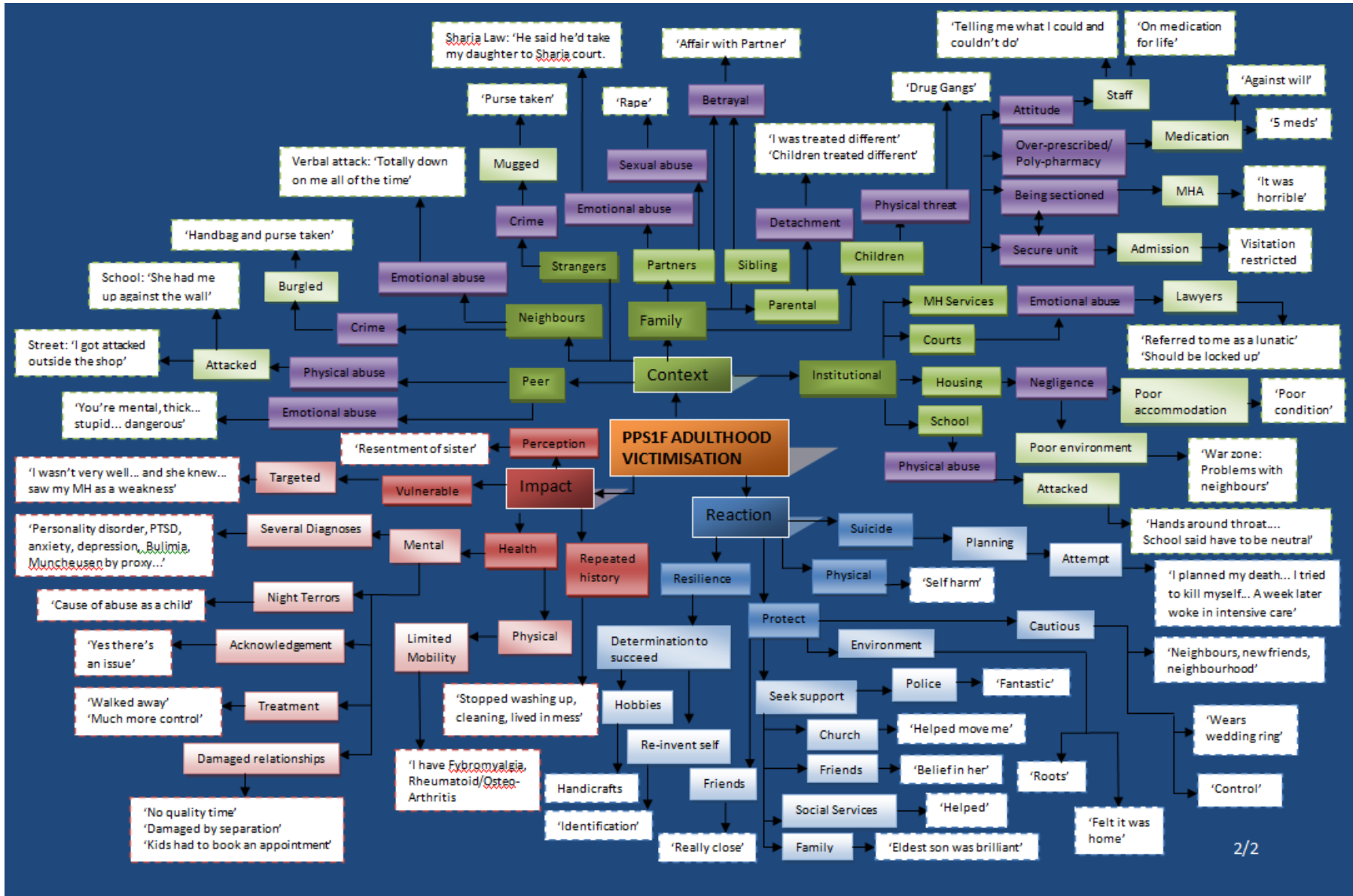
Environmental Influence: - Neighbourhood, Home, Sleeping arrangements, Hospital routine, Era, School, Vigilance.

Lack of Boundaries: - Parenting, Lack of guidance, Protection, Family Values, School values, Punishment, Friendships/Neighbours.

Coping Strategies: Resilience, Sense of Belonging, Detachment, Compliance, Sought protection, Friendship, Bully, Learning, Succumb.

Repeated History: - Reverted to childhood at the onset of MH crisis and on meds (Not washing up, unclean, like a slum), childhood bullying by adult neighbours.





Appendix 7f: Mind Maps. PPS1F.

Developing Emergent Themes: Participant PPS6F

Emergent Theme	Original Transcript	Exploratory Comments
<p>Context: Family abuse Vulnerability</p> <p>Reaction: Self-reliance</p> <p>Reaction: Detachment</p> <p>Powerless</p> <p>Context: Family abuse Vulnerability</p> <p>Context: Facade</p> <p>Family abuse: Rejection</p>	<p>Content removed due to data protection considerations</p> <p>considerations</p>	<p>Casual inclusion in conversation. Had to succumb</p> <p>Reaction to experience of abuse</p> <p>Withdrawal of self Coping strategy</p> <p>Reacted by detaching/rejecting Contempt</p> <p>Powerless. Had no voice and no choice</p> <p>Almost no justice</p> <p>Contrasting image of respectable/abusive</p>

<p>Parental neglect</p> <p>Impact: Alone in the world</p> <p>Family abuse: Parental neglect Vulnerability</p> <p>Reaction: Rescued Protection</p> <p>Impact: Blame Lack of bond</p>	<p>Content removed due to data protection considerations</p>	<p>Lack of love and protection</p> <p>No regard for child. Laughs to dismiss impact Rejected by mother and school</p> <p>Isolation, loneliness.</p> <p>Neglect and rejection from the start of life</p> <p>Almost reborn. A second chance.</p> <p>Recognises lack of care and responsibility from both parents.</p>
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CHILDHOOD		
CONTEXT:		
Superordinate Theme:	Line/Page:	Key Words
FAMILY:		
Parental: Neglect	13/7. 27/12. 36/12. 8/13.	Mum not there for me. Sent to school ill. Only 11 pounds when 9 months old. Seriously underweight
Parental: Absence	13/14. 30/13. 8/14	Mum not somebody I could go to. Didn't spend time with Dad. Not really a Dad.
Parental: Rejection	20/15. 32/15	Left with somebody in America. Left with a friend.
Parental: Physical Abuse	25/11. 10/16. 24/16	Mum angry, throw and hit. Chuck everything/Get hit It was a rage...
Parental: Sexual Abuse	1/12. 15/12.	Abused by my Dad. I was about 7... for a few years.
Parental Emotional Abuse	27/11.	She put me down all the time.
Grandparent Detachment	21/24	Couldn't have talked to them.
PEER:		
Peer Emotional Abuse	34/17	Call me names.
Peer Physical Abuse	22/17.25/17.17/14	On way home. Push me around. Bullied at school
REACTION:		
Superordinate Theme:	Line/Page:	Key Words
Protection: Family	2/13. 19/24	Grandparents fed me up. Felt like a child there.
Protection: Engage with Friends	26/18. 2/19.	Couple of really good friends. Three good friends.
Protection: Active: Escape	35/16. 10/17.	A bit of a haven. Safe really I suppose.
Protection: Comfort: Symbolic	13/17.	If my hair was up I wouldn't get bullied that day.
Resilience: Activity: Hobbies	1/17	Got involved in coaching. Had a lot of support.
Resilience: Self-reliance	5/12	I did feel I had to be responsible..
Resilience: Make Sense	23/39	You can't control who your family is...
Retaliate: Defiance	8/16. 18/16. 31/16.	I wouldn't tell her. I wasn't going to cry. I wasn't going to show her. Wasn't going to give her satisfaction.
IMPACT:		
Superordinate Theme:	Line/Page:	Key Words
Isolation: Lack of Friends	25/18. 26/18.	Didn't have a lot of friends. We moved.
Isolation: Withdrawn	32/14. 1/19.	I just kept to myself. Very much on my own.
Past: Poor Education	1/17. 9/17.	I struggled academically. Dyslexic.

Childhood Trauma: Physical, Sexual, Emotional Abuse, Neglect.

Attachment Style: Insecure

Mental Health Problem: Borderline Personality Disorder

Suicidal Ideation

ADULTHOOD		
CONTEXT:		
Superordinate Theme:	Line/Page:	Key Words
FAMILY:		
Parental: Rejection	15/13. 16/15.	Refused to loan money. Don't see kids
Grandparent: Rejection	16/15.	They want nothing to do with my kids.
Sibling: Absence	25/14.	Didn't talk for ten years.
Partner: Control	1/20. 28/20. 10/21.	Controlling. Pulled out of meeting. Do what he wanted.
Partner Physical Abuse	5/20. 21/20.	Tried to run me over. Tried to strangle me.
Children: Absence	9/7. 11/7.	There when in need. Son lives down south.
INSTITUTIONAL:		
MH Service: Control	10/9. 12/9. 18/9. 32/5. 19/10	ECT. Discharged after 5 months. Didn't understand. Don't like it at all. Lithium, Venlafaxine, +1 anti-depressant, Temazepam
MH Service: Rejection	34/9. 1/10.	Psychology/IAPT wouldn't see me
MH Service: Neglect	7/10. 22/7	They didn't explain. I ended up with a DVT and PE.
GP Services	9/26.	Woman of your age...
Physical Health: Stigma	34/25. 5/26.	Personality Disorder on top of notes. Labelled.
Work: Physical Abuse	12/22. 27/22.	I did get assaulted. Beaten up.
Work: Stigma	25/3. 10/4.	Wanted to get rid of me. I had to leave. No support.
REACTION:		
Superordinate Theme:	Line/Page:	Key Words
Protection: Seek support	16/5. 36/23.	Group/Individual Therapy. LMHC Floating support.
Protection Avoid	35/21. 6/22. 27/21. 10/6	I drive the long way round. Only go out in the car. Hide. Keep everything to myself.
Protection: Family	15/7. 35/13. 17/25.	Be there. Still coming with me. Really, really bad. Kept me going.
Protection: Environment	10/25. 21/25	My house is fine. I hate living in this city.
Resilience: Self Reliance	25/9. 33/19.	Like things done. Always been a 'super copper'.
Resilience: Self Reliance: Facade	12/6. 18/6. 14/21.	Notion I can cope. Not let people know. A front...
Resilience: Activity: Hobbies	20/19.	I've started making jewellery.
Retaliate: Against Self	21/25. 4/6. 2/9	Pictures will make it permanent. Behaviours like self harm. Feel really suicidal. Didn't want to carry on.
IMPACT:		
Superordinate Theme:	Line/Page:	Key Words
Well Being: Emotional Upset	17/20	I just snapped
Well Being: Mental Health	10/5. 23/5 25/5. 20/19	Still falling apart. Borderline Personality Disorder. Fell apart. Fell apart...
Isolation: Lack of Friends	10/19. 23/21.	Hard to make friends. Unsure of people.
Isolation: Damaged Relationships	6/24.	Don't trust.
Isolation: Withdrawn	16/11. 17/19.28/23	Don't go out. Quite on my own. Shut myself away.
Isolation: Circumstantial Limitation	21/6	Spend a lot of time on my own.
Perception: Negative Self	7/20. 18/22. 7/23.	Don't think a lot of myself. Think others think worst. I'm not worth it.
Perception: Vulnerability to Others	20/21.18/22. 32/21.19/26. 6/22	Try to please everybody. Others thinking the worst of me. Drive long way round. Very stupid/naughty little girl. I only go out in the car.
Perception: Lack of Future	32/24. 2/25.	Worried about getting a job. Don't see a future.
Perception: Vulnerability to Others	32/21.	Bit freaked out. Asked me out. Really freaked me out.

CHILDHOOD		
CONTEXT:		
Superordinate Theme:	Line/Page:	Key Words
FAMILY:		
Parental Rejection: Loss	12/4 17/4. 34/14. 9/15 32/17. 18/22 11/16. 20/16. 27/22	Dad died when I was 5 yrs old Mum died when I was 9 yrs old. Thought she hated me. Always thought I was going home. Told to live with Aunt and Nan. They knew. Wanted to go to the funeral but they said No! Punishment. Couldn't go.
Sibling: Emotional Abuse	31/15. 3/16	She hated me
Sibling: Physical Abuse	31/15	Hit us and that..
INSTITUTIONAL:		
Hospital Control: Restriction	10/5. 12/5. 3/17	Took me in... from 5-10 yrs old. Home now & then
School Control: Restriction	15/5. 19/5. 12/17	Missed infants and junior school. Hard to pick up
REACTION:		
Superordinate Theme:	Line/Page:	Key Words
Protection: Family	33/17	Live with Nan so not children's home
	20/5. 20/15. 1/21	Help with schooling. Got on well. Got us there
Protection: Active Avoidance	18/21. 23/21. 1/22	Walk away. Keep out of it. Life's too short
Protection: Active Escape	6/23	They kept an eye on me. Sit in staff room
Resilience: Engage with Friends	11/21	Had friends in the class
IMPACT:		
Superordinate Theme:	Line/Page:	Key Words
Well Being: Physical Health	28/16. 13/4	I got a lot of infections. Touch and go
Well Being: Mental Health	9/22	I was depressed and down
Well Being: Emotional Upset	20/17. 24/17.24/20	It used to get me down. Fed up. Sick of it
Isolation: Limitations	5/18. 6/22	From time I was young I've been on my own. Losing Siblings.
Isolation: Lack of friends	29/17. 4/18	Hard to make friends
Perception: Negative Self	20/23. 28/4. 9/15	Something I'd done? Hearing about me, finished him. Thought she hated me
Past: Education-Poor	8/20. 36/23. 5/24	School at ten yrs old. Fed up. No interest in college
Past: Continued Influence	2/15. 15/16.	Missed Mum. Miss them too.

Childhood Trauma: Loss and Traumatic Event.

Attachment Style: Insecure

Mental Health Problem: Severe Depression

ADULTHOOD		
CONTEXT:		
Superordinate Theme:	Line/Page:	Key Words
FAMILY:		
Partner Neglect	16/3.	Worked away. Drink and football
Partner Financial abuse	9/9. 1/9. 5/27	Bailiffs. Still hurts with debt. Hurt with debt he left.
Partner Rejection	27/2. 5/27	Went off with her. Went off with friend.
PEER:		
Neighbour: Verbal Threats	30/6. 6/6. 21/6	She's nasty with me. She's a nasty piece of work. Shouting and swearing.
INSTITUTIONAL:		
MH Service: Ineffective Authority	29/27	Can only give us these tablets...
GP: Ineffective Authority	18/12	Can't get to see your own GP...
OT: Ineffective Authority	6/13. 32/28. 10/29	Lot of trouble. They don't do nothing...
Social Services: Neglect	9/14. 16/8. 11/13	Been mucked about. Don't work with you anymore.
Housing Neglect	8/8.	Reporting and reporting, they don't come out.
REACTION:		
Superordinate Theme:	Line/Page:	Key Words
Protection: Active Avoidance	36/3. 13/29. 23/29	I just give up. Just stay away. Don't care
Protection -Seek support	5/3. 24/12 25/7. 30/8.15/8 20/25 1/4. 6/11. 33/15 18/13. 10/14 22/9	MH Charity. Best thing. Lovely. Sort things Community M H Nurse. My CPN. God send Friends. Couple of people Family. 6 daughters. Close to sister Age Concern/UK. Told them. Made calls Citizen's Advice. I got that sorted
Protection:		
Environment: Home security	20/27. 31/26	Windows & front door are locked. Shut blinds
Environment: Neighbourhood	32/25	Nice area... nice people. It's nice
Resilience: Self-Reliance	15/10. 3/8. 3/11	Get out of depression. Got to be me. Snap out.
Retaliate: Against Self	10/28. 13/28	Not really bothered about the flat. No interest
Retaliate: Self-defence	23/21.27/21.	Stick up for myself.
Retaliate: Against Others	20/3	Walking out of marriage.
IMPACT:		
Superordinate Theme:	Line/Page:	Key Words
Well Being: Physical Health	33/9. 3/10. 19/10	Migraine. Irritable Bowel. Twisted spine
Well Being: Mental Health	18/11. 11/12. 4/26	Deep depression. It's horrible. Hearing voices
Well Being: Fear	23/26 17/7. 25/26 14/11. 23/14	I get frightened hearing voices Her voice frightens me. So scared of her Frightened of them. Get frightened
Well Being: Emotional Upset	6/3. 29/28	All got on top of me. Angry.
Isolation: Withdrawn	25/25. 21/26.	Cannot do much. Don't go anywhere.
Isolation: Circumstantial Limitations	24/24. 18/25. 4/7. 2/25	Sit in house. Stuck. Won't go out. Hell of a long time on your own
Isolation -Loneliness	25/9. 9/18. 13/18	Lonely. On my own again, aren't I? Hate
Perception: Lack of Future	5/28.	No future.
Perception: Negative Self	30/7. 29/11 29/3. 1/4	Knocks. Everything comes back Walking out. Still a bit of guilt
Perception: Vulnerability to Others	17/29. 4/27	They don't realise the damage. Hurt badly
Past: Continued Influence	26/11. 10/16	Miss her today. Remember things. Come back
Past: Education-Poor	14/20. 21/5. 30/23. 34/23	Not good. Not 100%. No qualifications. Problems

Appendix 7j: Childhood Peer Abuse and Stigma.

<u>Experience of Abuse and Stigma from Peers</u>	Line:
ABUSE	
Content removed due to data protection considerations	18/32
	6/33
	28/32
	14/34
	35/33
	29/15
	26/20
	28/35
	30/36
	17/14
	22/17
	34/17
	5/3
	19/44

Content removed due to data protection considerations

19/42

16/43

27/44

29/31

1/39

27/23

1/24

2/12

1/14

23/14

6/15

10/15

34/15

9/17

26/17

Content removed due to data protection considerations	28/21 24/20 17/22 6/5
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Appendix 7jj: Adulthood Family Abuse, Neglect and Stigma.

<u>Context: Experience of Abuse, Neglect and Stigma in the Family</u>	Line:	Considerations
<p>ABUSE</p> <p>Content removed due to data protection considerations</p>	8/13	<p>Emotional</p> <p>Powerless</p>
	12/13	<p>Physical</p> <p>Violent</p>
	27/25	<p>Physical</p> <p>Violent</p>
	26/12	<p>Vulnerable</p> <p>Psychological</p>
	24/57	<p>Threats</p> <p>Psychological</p>
	17/23	<p>Physical</p>
	21/43	<p>Sexual</p> <p>Violent</p>
	5/60	

Content removed due to data protection considerations	21/20	Psychological
		Physical
		Familiar Acceptance
	18/21	
		Violent Physical Discarded
	19/33	
		Violence Attempted murder
	5/27	
	Financial abuse	
20/58		
	Inter- generational abuse	
2/25		
	Psychological	
	Withdrawal Isolation	

<p>STIGMA</p> <p>Content removed due to data protection considerations</p>	<p>26/13</p>	<p>Banished</p>
		<p>Dismissive Psychological</p>
		<p>Emotional</p>
		<p>Degraded</p>
	<p>33/9</p>	<p>Disowned</p>
		<p>Banished</p>
	<p>6/34</p>	<p>Inter- generational</p>
		<p>No respect Disregard</p>

Appendix 7k: Childhood Reaction: Protection.

	Line:	Consideration:
ACTIVE - SEEK SUPPORT		
Content removed due to data protection considerations	33/25	Failed attempt to alert parent.
	17/16	
		Screamed out for Mum and she came.
		Very traumatic
	26/19	Teachers support Favourite
	22/42	
		Taken seriously
	23/43	
	20/14	
	10/34	Seek help
16/28		

Content removed due to data protection considerations		Not listened to.
ACTIVE - AVOIDANCE		Concern for
Content removed due to data protection considerations	20/8	isolation
	22/9	
	27/18	Escape
		Avoid Father
	1/19	
		Avoid bullies.
	18/21	Self-protection
		Avoid trouble at
	1/22	school
	12/18	
		Self-protection
	1/34	
		Isolation
		Safe environment

Appendix 7kk: Adulthood Reaction: Retaliate.

Retaliate: Against Self	Line:	Considerations
Content removed due to data protection considerations	25/19	Negative self image
	21/17	Suicide Preparation
	11/18	Intent
	28/44	Medication Control
	10/12	Negative self Thoughts
	4/6	Facade Self-harm
	2/9	Overwhelmed

Appendix 7I: Childhood Impact: Isolation.

ISOLATION	Line:	Consideration
LACK OF FRIENDS Content removed due to data protection considerations	19/33	Marginalised Rejection
	5/18	Isolated. Alone
	6/11	No
	18/25	Impact on self
	6/6	Moved school Isolated Confused
	29/17	Moved. Lonely
	25/18	Moved house Powerless
	21/27	Moved house
	6/39	Negative influence Loner Isolated

<p>Content removed due to data protection considerations</p>	<p>24/20</p>	<p>Rejected</p> <p>Isolated</p> <p>Target</p> <p>Confidence</p>
<p>ISOLATION: WITHDRAWN</p>	<p>13/25</p>	<p>Self-identity</p>
<p>Content removed due to data protection considerations</p>	<p>32/14</p>	<p>Self-removal</p> <p>Acceptance</p>
	<p>1/19</p>	<p>Different</p> <p>Self-identity</p>
	<p>27/27</p>	<p>Self-identity</p>
	<p>18/18</p>	<p>Withdrawal</p> <p>Self-</p> <p>withdrawal</p>
	<p>35/19</p>	
	<p>35/20</p>	<p>Acceptance</p>
	<p>15/20</p>	<p>No human</p> <p>connection</p>

Appendix 7II: Adulthood Impact: Isolation.

ISOLATION	Line:	Considerations
Circumstantial Limitations		
Content removed due to data protection considerations	24/24	Alone
	18/25	No choice Mobility
	4/7	Lack of confidence
	21/6	Isolated Alone
	28/13	Caged
	24/30	Lonely Decision- making Connections
	2/16	Confidence Support
	22/29	Isolated
	21/4	Difficulties Isolated
	14/23	Social isolation

Content removed due to data protection considerations		
Withdrawn		
Content removed due to data protection considerations	25/25	Motivation
	16/11	Familiarity Alone Self-reliance
	5/20	Self-reliance Lack of trust Alone
Loneliness		
Content removed due to data protection considerations	25/9	Feeling lonely
	9/18	Alone since childhood
		No support Emotional Impact

Content removed due to data protection considerations	17/16	Alone Isolation
Lack of Friends		
Content removed due to data protection considerations	31/45	No bonding
	19/16	Reliance Loss Withdrawal
	1/11	Being taken advantage of
	27/19	Withdrawal
	10/19	Social difficulty
considerations	23/21	Negative self- perception Trust

Superordinate Themes for: Childhood Context	1F	8M	10M	3F	4M	6F	5F	12F	11M	9M	14F	16F	17F	18F	20M	Present in over half the sample
Abusive Experience	X	X	X	X	X	X	X	X	X	X		X	X	X	X	14
Rejection	X	X		X	X	X	X	X	X	X	X	X	X	X	X	14
Control		X	X	X	X			X				X		X	X	8
Subordinate Themes:																
FAMILY:																
Neglect	X	X	X			X			X							5
Physical Abuse	X	X	X			X		X				X	X		X	8
Sexual Abuse	X					X	X					X				4
Emotional Abuse	X	X	X	X		X	X	X					X	X	X	10
Stigma			X													1
Domestic Abuse			X					X	X			X			X	5
Rejection	X					X	X	X			X	X	X		X	8
Absence					X	X		X					X		X	5
Loss				X	X		X						X			4
Control								X						X	X	3
Restriction		X						X				X				3
PEER:																
Emotional Abuse	X	X				X		X					X		X	6
Physical Abuse	X		X			X		X	X				X		X	7
Sexual Abuse	X							X								2
Rejection	X	X			X								X	X		5
Bullying	X															1
INSTITUTIONAL:																
Physical Abuse	X		X					X	X	X						5
Neglect	X				X			X								3
Emotional Abuse	X							X								2
Sexual Abuse								X								1
Rejection		X			X				X							3
Ineffective								X					X		X	3
Restriction				X	X											2
Control			X					X								2

Appendix 7m: Cross-Case Identification of Recurrent Themes. Context

Superordinate Themes for: Adulthood Context	1F	8M	10M	3F	4M	6F	5F	12F	11M	9M	14F	16F	17F	18F	20M	Present in over half the sample
Abusive Experience	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	15
Rejection	X	X	X	X	X	X	X	X	X	X	X	X		X	X	14
Control	X	X	X			X	X	X	X	X	X	X		X	X	12
Subordinate Themes:																
FAMILY:																
Sexual Abuse	X															1
Emotional Abuse	X	X	X		X		X	X			X					7
Physical Abuse					X	X		X		X	X			X		6
Financial Abuse			X	X				X			X					4
Neglect				X												1
Stigma			X							X	X			X		4
Rejection	X			X	X	X	X	X	X			X		X	X	10
Absence						X	X	X						X		4
Loss							X		X							2
Control						X	X	X			X				X	5
Restriction			X								X	X			X	4
PEER:																
Emotional Abuse	X	X	X	X	X		X	X	X	X	X					10
Physical Abuse	X		X		X				X			X				5
Financial Abuse		X													X	2
Sexual Abuse		X														1
Stigma	X		X							X	X	X				5
Crime Against	X						X		X			X				4
Rejection									X							1
INSTITUTIONAL:																
Neglect	X	X		X		X	X	X	X	X	X	X	X	X		12
Emotional Abuse			X		X	X	X	X		X				X		7
Physical Abuse											X					1
Sexual Abuse								X								1
Financial Abuse		X	X											X		3
Stigma	X		X			X		X		X	X	X		X		8
Rejection			X		X	X	X	X	X	X	X	X				9
Loss					X											1
Ineffective	X		X	X				X	X	X		X				7
Restriction			X						X		X					3
Control	X	X	X			X	X	X	X	X	X	X		X	X	12

Superordinate and Subordinate Themes for: Childhood Reaction	1F	8M	10M	3F	4M	6F	5F	12F	11M	9M	14F	16F	17F	18F	20M	Present in over half the sample
PROTECTION:	X	X	X	X	X	X	X	X		X		X	X	X	X	13
Active Escape				X		X		X				X		X		5
Active Seek Support	X				X		X	X				X	X		X	7
Active Avoidance	X			X	X					X			X		X	6
Comfort Symbolic						X										1
Family Support		X	X	X	X	X				X			X	X	X	9
RESILIENCE:	X		X	X	X	X	X	X	X	X	X	X	X	X	X	14
Engage with Friends	X		X	X		X	X		X		X	X	X	X		10
Activity: Occupation									X	X				X		3
Activity: Hobbies			X			X			X			X	X			5
Make Sense	X		X		X	X	X	X				X	X		X	9
Self-Reliance						X							X		X	3
Self-Reliance: Determination														X		1
RETALIATE:	X	X			X	X	X	X		X		X	X			9
Against Others	X	X										X	X			4
Against Self	X							X								2
Commit Crime		X			X							X				3
Defiance					X	X	X	X					X			5
Self-Defence										X						1

Superordinate and Subordinate Themes for: Adulthood Reaction	1F	8M	10M	3F	4M	6F	5F	12F	11M	9M	14F	16F	17F	18F	20M	Present in over half the sample
PROTECTION:	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	15
Active Seek Support	X		X	X	X	X	X	X	X	X	X	X		X	X	13
Active Escape														X	X	2
Active Avoidance	X			X	X	X			X	X	X	X	X	X	X	11
Environmental: Neighbourhood	X	X		X	X		X	X	X	X	X		X	X	X	12
Environmental: Home Security	X		X	X	X	X	X		X							7
Family Support		X			X	X	X	X		X			X	X		8
Comfort Symbolic			X													1
Comfort Religion										X						1
RESILIENCE:	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	15
Engage with Friends	X						X				X	X			X	5
Activity: Hobbies	X		X		X	X	X	X	X			X	X		X	10
Activity: Occupation		X			X		X				X	X		X	X	7
Make Sense	X	X			X		X	X		X	X	X	X	X	X	11
Self-Reliance: Facade					X	X										2
Self-Reliance: Re-Invent Self	X															1
Self-Reliance: Determination				X	X	X	X				X	X	X	X	X	9
RETALIATE:		X	X	X	X	X	X	X	X	X	X	X	X	X	X	14
Against Others			X	X	X			X	X	X			X	X		8
Against Self		X	X	X	X	X	X		X		X	X	X			10
Commit Crime															X	1
Self-Defence		X		X	X		X	X		X					X	7
Defiance									X	X				X		3

Superordinate and Subordinate Themes for: Childhood Impact	1F	8M	10M	3F	4M	6F	5F	12F	11M	9M	14F	16F	17F	18F	20M	Present in over half the sample
Well Being:																
Physical Health	X			X	X								X			4
Mental Health				X				X					X		X	4
Low Self-Esteem					X			X							X	3
Fear	X		X					X								3
Emotional Upset		X		X								X			X	4
Isolation:																
Loneliness					X											1
Withdrawn					X	X						X		X	X	5
Circumstantial Limitation				X				X							X	3
Lack of Friends	X	X		X		X						X		X	X	7
Disempowerment								X							X	2
Perception:																
Negative Self		X		X	X							X				4
Vulnerability to Others								X				X				2
Past:																
Poor Education		X	X	X	X	X	X	X	X	X			X	X		11
Continued Influence				X												1

Super-ordinate Themes and Themes for: Adulthood Impact	1F	8M	10M	3F	4M	6F	5F	12F	11M	9M	14F	16F	17F	18F	20M	Present in over half the sample
Well Being:																
Physical Health	X	X		X	X		X	X	X	X	X	X	X			11
Mental Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	15
Low Self-Esteem								X			X		X	X	X	5
Fear		X		X				X			X	X		X		6
Emotional Upset		X	X	X	X	X		X				X		X		8
Isolation:																
Loneliness				X	X				X							3
Withdrawn				X		X		X								3
Circumstantial Limitation				X		X	X	X	X	X	X				X	8
Lack of Friends						X		X	X	X				X		5
Disempowerment			X				X	X								3
Damaged Relationships	X		X			X	X			X					X	6
Perception:																
Negative Self		X	X	X	X	X					X				X	7
Vulnerability to Others	X		X	X	X	X		X	X	X		X		X	X	10
Lack of Future			X	X	X	X										4
Past:																
Poor Education				X												1
Education Interrupted													X	X	X	3
Continued Influence	X	X		X	X			X				X	X		X	8

Appendix 7p: Childhood Context, Reaction and Impact Hierarchy

Overarching Theme	Superordinate Theme	Subordinate Themes			
Context of Childhood Trauma	Abusive Experience	Sexual Abuse	F	P	‡
		Physical Abuse	F	P	‡
		Emotional Abuse	F	P	‡
		Neglect	F		‡
		Stigma	F		
		Domestic Abuse	F		
	Rejection	Rejection	F	P	‡
		Absence	F		
		Loss	F		
		Ineffective			‡
	Control	Controlled	F		‡
		Restricted	F		‡
	External Life Events	Maternal Illness	F		
		Marital Status	F		
		Lived Abroad	F		
		Religion	F		
		Poor School	F		
		School Move	F		
		Home Move	F		
Sibling Abuse		F			
Divorce		F			
Special Needs		F			
Key:					
Family = F					
Peers = P					
Institutional = ‡					

Overarching Theme	Superordinate Theme	Subordinate Themes			
Reaction to Experience	Protection	Active Escape			
		Active Seek Support			
		Active Avoidance			
		Comfort Symbolic			
		Family Support			
	Forms of Resilience	Engage with Friends			
		Activity: Hobbies			
		Activity: Occupation			
		Making Sense			
		Self-Reliance			
		Self-Determination			
	Retaliate	Against Others			
		Against Self			
		Commit Crime			
		Defiance			
		Self-Defence			

Overarching Theme	Superordinate Theme	Subordinate Themes
Impact on the Self	Well Being	Physical Health
		Mental Health
		Low Self Esteem
		Fear
		Emotional Upset
	Isolation	Loneliness
		Withdrawn
		Circumstantial Limitation
		Lack of Friends
		Disempowerment
	Perception	Negative Self
		Vulnerability to Others
	Past	Poor Education
		Continued Influence

Appendix 7q: Adulthood Context, Reaction and Impact Hierarchy

Overarching Theme	Superordinate Theme	Subordinate Themes			
Context of Adulthood Trauma	Abusive Experience	Sexual Abuse	F		
		Physical Abuse	F	P	‡
		Emotional Abuse	F	P	‡
		Financial Abuse	F	P	
		Neglect	F		‡
		Stigma	F	P	‡
		Crime Against		P	
	Rejection	Rejection	F	P	‡
		Absence	F		‡
		Loss	F		‡
		Ineffective Authority			‡
	Control	Controlled	F		‡
		Restricted	F		‡
	Parental Influence	Maternal Illness	F		
		Parental Death	F		
Prosecution		F			
<p>Key: Family = F Peers = P Institutional = ‡ (Police, GP Services, Physical Healthcare, Social Services, Mental Health Services, Courts, Local Mental Health Charity, Religion, Work, Bank, Housing).</p>					

Overarching Theme	Superordinate Theme	Subordinate Themes			
Reaction to Experience	Protection	Active Escape			
		Active Seek Support			
		Active Avoidance			
		Environmental: Neighbourhood			
		Environmental: Home Security			
		Comfort Religion			
		Comfort Symbolic			
		Family Support			
	Resilience	Engage with Friends			
		Activity: Hobbies			
		Activity: Occupation			
		Make Sense			
		Self Reliance – Façade			
		Self Reliance: Re-invent Self			
	Retaliate	Self Reliance - Determination			
		Against Others			
		Against Self			
		Commit Crime			
		Self Defence			
		Defiance			

Overarching Theme	Superordinate Theme	Subordinate Themes
Impact on the Self	Well Being	Physical Health
		Mental Health
		Low Self Esteem
		Fear
		Emotional Upset
	Isolation	Loneliness
		Withdrawn
		Circumstantial Limitations
		Lack of Friends
		Damaged Relationships
		Disempowerment
	Perception	Negative Self
		Lack of Future
		Vulnerability to Others
	Past	Education Poor
		Education Interrupted
Continued Influence		

Appendix 7r: Final Three Master Themes

1. The Nature of Traumatic Experience

Themes			Participants														Present in over half of the sample										
Master Theme	Superordinate Theme	Subordinate Themes	I	J	A	A	P	O	S	W	J	N	E	E	S	I		F									
			s	a	m	v	p	s	o	p	h	i	a	m	a	o	v	i	e	a	r	e	t	t	e	e	
The Nature of Traumatic Experience	Maltreatment	Abuse: <i>Sexual</i>			X	v	v	O	X						v											No	
		<i>Physical</i>		O	X	X		v	X	X	X	X	O	X	O	X	v	O	v								Yes
		<i>Emotional</i>	X	O	X	X	X	X	X	X	X	O	O	O		v	X	v									Yes
		<i>Witness</i>								v	v		v		v												No
		<i>Financial</i>	O		O				O	O	O		O	O				O	O					O	O		Yes
	Neglect	O	v	X	X	v	X	X	v	O	v		X	X	X	v	X	X									Yes
	The Disbelief of Rejection	Disregarded	O	X	X	X	X	v	X	O	v	X	X	X	v	X	X										Yes
		Loss: <i>Absence</i>		v		X	X		X								v	O	v								No
		<i>Death</i>	v	v			O							O			v										No
	Powerlessness of Family Life	Stigma			O	O				O	O	O			O	O								O			Yes
Restricted by Control		v	v	v	X	X	X	X	X	X	O	O	O	O	X								v	X		Yes	
		Familial Influence						X	v	v	v	X	v	v	v	v								X		Yes	

Key:
v = Childhood,
O = Adulthood,
X = Both child and adulthood

2. Coping and Adaptation to Childhood Trauma

Themes			Participants														Present in over half of the sample											
Master Theme	Superordinate Theme	Subordinate Themes	I	J	A	A	P	O	S	W	J	N	E	E	S	I		F										
			s	a	m	v	p	s	o	p	h	i	a	m	a	o	v	i	e	a	r	e	t	t	e	e		
Coping and Adaptation to Childhood Trauma	Protection	Seeking Support	v	X	X	X	X	X	X	X	X	X	O	O	X	X	X	X									Yes	
		Active Avoidance	X	X	X	X				v	X	X	O	O	X	X	X	X									Yes	
		Environmental: <i>Home Security</i>	O	O	O	O	O					O		O													No	
		<i>Neighbourhood</i>	O	O	O		O	O	O			O	O	O			O	O						O	O	O		Yes
	Repressive Coping	Engage with friends	v		X	v	X					v		v	X	X	v	v	O								Yes	
		Activity		O	O	X	O	O	O	O	X	v	X	O	X	X	X	X	O							O		Yes
		Sensemaking		O	X	v	X	O	X	v	O				O	X	X	O	X									Yes
		Self-enhancement	O	O	O	X	O									O	O	X	X	X								Yes
	Retaliation	Against Self	O	O	v	O	O	O	v	O			O	O	O	O											Yes	
		Against Others:	O	X	v	v	v	X	X			X	O		v	v	O	O									Yes	

Key:
v = Childhood,
O = Adulthood,
X = Both child and adulthood

3. The Impact of Childhood Trauma

Themes			Participants																
Master Theme	Superordinate Theme	Subordinate Themes	Isla	Jacob	Ameilia	Ava	Poppy	Oscar	Sophia	William	Jamies	Noah	Eve	Ella	Scarlett	Isabelle	Fredie	Present in over half of the sample	
The Impact of Childhood Trauma	Distorted Perception	Negative Self	X	X		O		X		O			O	√			X	Yes	
		Vulnerability to others	O		O	O				O	O	O	O		O	√	O	X	Yes
	Segregation	Isolation:	X	X	√	X	O		X		O	O	O	√		√	X	Yes	
		Lack of Close Relationships			X	X		X	O	O	O	O		√		X	X	Yes	
		Limited Education	X	√		√	√	√	√	√	√		√		O	X	X	O	Yes
	Poverty of Well Being	Physical health	X	X	X	O	O	O	O		O	O	O	O	O	X			Yes
		Emotional health:	X	X	√	O			X	X	X			O	X	O	O	X	Yes
		Mental health	X	O	O	O	O	O	X	O	O	O	O	O	O	X	O	X	Yes

Key:
 √ = Childhood,
 O = Adulthood,
 X = Both child and adulthood

Appendix 8a: The Data Protection Act

The [Data Protection Act](#) controls how your personal information is used by organisations, businesses or the government.

Everyone responsible for using data has to follow strict rules called 'data protection principles'. They must make sure the information is:

- used fairly and lawfully
- used for limited, specifically stated purposes
- used in a way that is adequate, relevant and not excessive
- accurate
- kept for no longer than is absolutely necessary
- handled according to people's data protection rights
- kept safe and secure
- not transferred outside the [European Economic Area](#) without adequate protection

There is stronger legal protection for more sensitive information, such as:

- ethnic background
- political opinions
- religious beliefs
- health
- sexual health
- criminal records

Source: <https://www.gov.uk/data-protection/the-data-protection-act>

[Accessed: 07.08.16]

Appendix 8b: The Code for Nurses and Midwives

Prioritise people

- 1 Treat people as individuals and uphold their dignity
- 2 Listen to people and respond to their preferences and concerns
- 3 Make sure that people's physical, social and psychological needs are assessed and responded to
- 4 Act in the best interests of people at all times
- 5 Respect people's right to privacy and confidentiality

Preserve safety

- 13 Recognise and work within the limits of your competence
- 16 Act without delay if you believe that there is a risk to patient safety or public protection
- 17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection
- 19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

Promote professionalism and trust

- 20 Uphold the reputation of your profession at all times**
- 21 Uphold your position as a registered nurse or midwife

Source: <https://www.nmc.org.uk/standards/code/read-the-code-online/#second>

[Accessed: 08.07.16]

Appendix 8c: Ethical Approval

Content removed due to data protection considerations

Appendix 10a: Two-Dimensional Construct of Adult Self-Image and Image of Others

Some materials have been removed from this thesis due to Third Party Copyright and confidentiality considerations. Pages where material has been removed are clearly marked in the electronic version. The unabridged version of the thesis can be viewed at the Lanchester Library, Coventry University.

Bartholomew, K. (1990) 'Avoidant of Intimacy: An Attachment Perspective',
Journal of Social and Personal Relationships, 7 (2): 147-178.