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Written Exercise 1

The National Service Framework (DOH, 1999) places primary care in the forefront of service provision for adult mental health. Outline mental health services for adults in primary care and critically discuss the role of clinical psychologists working in such services.

INTRODUCTION

The role of clinical psychologists within the NHS has developed in many ways since the creation of the NHS in 1948. This essay will focus on the work of clinical psychologists in primary mental health care. The traditional view of primary health care is of a visit to your General Practitioner (GP). However, as noted by Nolan and Badger (2002), a new contract for GPs in 1990 allowed them greater flexibility in the categories of staff that they could employ. This has resulted in a range of staff working within primary care services, including nurses, counsellors and clinical psychologists.

This essay begins with an outline of The National Service Framework for adult mental health (NSF) (DOH, 1999). The NSF sets out guidelines for what primary care services should provide in terms of mental health care. It will become apparent that the NSF does place primary care at the forefront of mental healthcare provision. This will lead to an overview of the work of counsellors and clinical psychologists, who may appear to deliver similar services. At present there do not seem to be clear guidelines concerning the organisation of mental health services for adults in primary care. I will discuss some of the sources of confusion that this brings for clinical psychologists working in primary and secondary care. Following this, I will present evidence supporting the use of a collaborative model between GPs and clinical psychologists. Next I will overview the therapeutic role of clinical psychologists and discuss evidence evaluating Cognitive Behaviour Therapy (CBT) and counselling in primary care. This will lead to a discussion on the treatment that clinical psychologists can provide in primary care and how this fits with the NSF. I feel much greater use of clinical psychology, beyond the most obvious role of therapist, could facilitate achievement of the NSF proposals. However, there are questions that need to be

addressed in order to help establish clinical psychologists in future primary mental health care services, particularly in view of the agenda for change.

THE NATIONAL SERVICE FRAMEWORK FOR MENTAL HEALTH

Approximately 6 million people a year consult their GP with a problem that is related to their mental health (Nolan and Badger, 2002, p7). One in four people in the community have a mental health problem and 90% of people with mental health problems are cared for entirely within primary care (Goldberg and Huxley 1992, cited in McCulloch 2002, p6). Primary health care describes the nearest contact that individuals have with their local health service (Marzillier, 1999, p297). As Marzillier notes, the traditional view of primary care is of a visit to your GP, who acts as the 'gatekeeper' to the specialist hospital services. However, it may be more useful to consider an alternative definition of primary care that includes the professionals that work in these services. For example, Rogers and Pilgrim (2001, p144) define primary care as 'the organizational aspects of formal service provision, such as general practice and primary health care teams, with other practitioners operating at the periphery'.

Given the figures above it is evident that primary care plays a central role in meeting the mental health needs of the population. This role is outlined in standards two and three of the NSF. For the purpose of this essay I shall focus on standard two, because standard three focuses on the provision of 24 hour care that clinical psychologists would not typically be involved in.

Standard Two states that:

Any service user who contacts their primary mental health care team with a common mental health problem should have their mental health needs identified and assessed and be offered effective treatments, including

referral to specialist services for further assessment, treatment and care if they require it (DOH, 1999, p28)

To meet standards two and three, the NSF states that each primary care group will need to work with the support of specialist mental health services to:

- develop resources within each practice to assess mental health needs
- develop resources to work with diverse groups within the population
- develop the skills and competencies to manage common mental health problems
- agree the arrangements for referral for assessment, advice or treatment and care (DOH, 1999, p35)

The NSF states that the majority of mental health problems will be treated within primary care as at present. By introducing protocols for assessment and management within primary care, the NSF aims to ensure that more complex cases are able to access specialist assessment and treatment, including psychological therapies and continuing care. In the next section I will briefly outline counselling and clinical psychology in primary care, because later in the essay I will consider how these professions contribute to the implementation of these guidelines.

COUNSELLING AND CLINICAL PSYCHOLOGY IN PRIMARY CARE

Generally, it seems that the number of counsellors and clinical psychologists in primary care mental health services is increasing. For example, Marzillier (1999) suggested that about half of GP practices have a counsellor attached in some

way. Papworth (2000) noted that in his local primary care group the number of adult primary care psychology posts had risen from 2 to 8 in two years.

In order to critically discuss the role of clinical psychologists effectively I feel that it is useful to compare their role to that of counsellors. They both use talking treatments and therefore they may seem to deliver a similar service. The document 'Treatment Choice in Psychological Therapies and Counselling' (DOH, 2001), notes the confusion concerning definitions of the term 'counsellor' in the NHS. The common practice is to denote all psychological therapy in primary care as 'counselling', when in fact the training and type of intervention that the therapist delivers may vary considerably. For example, a counsellor may use a humanistic approach, or be a trained psychotherapist practising psychodynamic psychotherapy. For the purpose of this essay, I will adopt the definition of counselling used by the DOH, which views counselling as a 'systematic process which gives individuals the opportunity to explore, discover and clarify ways of living more resourcefully, with a greater sense of well being' (DOH, 2001). As noted in DOH (2001), most counsellors are influenced by humanistic, experiential and psychodynamic principles. When comparing counselling and clinical psychology I feel that it is important to consider the perspective of GPs who are buying services from these two professions. Counsellors cost less than clinical psychologists and are able to spend more of their time in direct client contact, which makes them appealing to purchasers on tight budgets (Marzillier, 1999). I will look at some research investigating counselling and clinical psychology later in this essay. However, I will focus next on the work of clinical psychologists.

The British Psychological Society (BPS) states that clinical psychologists use their 'multi-theory based training to apply scientific knowledge to formulate problems in psychological terms and offer effective interventions' (BPS, 1998). An important difference between their training and that of counsellors is that they are trained in the use of a number of therapeutic models, which enables them to draw from a wide therapeutic base. They can provide consultancy, training and

supervision to other professionals and are able to conduct audits and research. Although counsellors may be able to provide these skills, it may depend on the type of training that they have received. One of the key differences in the work of psychologists in comparison to medical professions is that they do not diagnose mental health problems within a medical model. The use of diagnostic categories tends to prescribe a pre-determined method of treatment that may overlook individual differences (e.g. France and Robson, 1997). Instead, following their psychological assessment, clinical psychologists use their skills in formulation to describe how a problem has developed and offer effective interventions that are based on scientific knowledge and evidence-based practice. Following this outline of their work, I would like to discuss how services are organised.

THE ORGANISATION OF SERVICES IN PRIMARY CARE

I have encountered some confusion amongst psychologists working in adult mental health about whether their work is within primary care or secondary care. This is my impression from discussions with clinical psychologists working in the psychology department where I am currently on placement. I think that part of this confusion is related to the fact that psychologists are often working on the interface between primary care and secondary care. For clinical psychologists employed within GP practices their work is clearly within primary care. However, for clinical psychologists working within Community Mental Health Teams (CMHTs) there are a number of referral pathways from GPs. For example, the referral may be discussed with the CMHT first, or the psychologist may receive the referral directly from the GP without the rest of the CMHT being involved. When a clinical psychologist works directly with a GP but is based in a CMHT it may not be clear whether the work constitutes primary or secondary care. The

organisation of services can therefore create confusion for psychologists within CMHTs.

The confusion surrounding service organisation that I have seen on placement is reflected in some of the literature on primary care services. For example, Walters and Tylee (2002) note that there is no clearly defined model for the provision of primary care mental health services and practices tend to develop their skills and services to meet the needs of the local population. They note that some health trusts have created primary mental health teams, which often consist of a community psychiatric nurse, counsellor and / or psychologist, practice nurse and a GP. I think that the development of teams like this in the future would help to reduce the confusion experienced by psychologists within CMHTs. This is because there would be a clearer service structure where their role would be more clearly defined. Indeed Papworth (2000) has advocated that clinical psychologists could work in a similar role to that of GPs, because their training enables them to work across a range of issues. Given their knowledge, they would be in a good position to offer a therapeutic intervention, or make a referral to other more specialised services if this was appropriate. This would fit with DOH (2001) guidelines that more severe or complex mental health problems should receive secondary specialist treatment.

From this discussion it appears that there is a need to develop a clear model of service delivery in primary care and the establishment of more primary care teams could help in this manner. An additional service related issue is that clinical psychologists are often at the periphery of services in primary care. I feel that being on the periphery of services means that other professionals have limited understanding of our role within services. More importantly, I have seen on my current placement that provisional talks on plans to develop a local primary mental health care service were conducted without the involvement of the psychology department. This is a great loss to the development of services where I am on placement. Clinical psychologists can use their knowledge to contribute

to discussions on what a primary mental health care team could look like and the contribution that psychologists could make to these services. If this is a reflection of other services, then it would seem that clinical psychologists may need to educate other professionals on the role they could play in service development. This would also ensure that their skills are used effectively to develop services that meet NSF guidelines. In the next section I will discuss evidence supporting collaborative care between GPs and clinical psychologists, which could be a useful model for primary care services to adopt.

COLLABORATIVE CARE INVOLVING GPs AND PSYCHOLOGISTS

I have established above that a huge responsibility for mental health provision is located within primary care. As gatekeeper, the GP plays a crucial role in mental health care, but researchers have raised concerns over their ability to detect mental health problems. For example, Goldberg and Huxley (1992), cited in McCulloch (2002) have suggested that of the 250 people in every 1000 who have a mental health problem, 230 per 1000 would attend their GP surgery. However, they note that only 130 people per thousand are identified as having a mental health problem. Walters and Tylee (2002) felt that there is a deficit in the mental health training of GPs and that this must be addressed if they are to continue in their gatekeeper role. Given these pressures on GPs to meet the mental health needs of their patients, I think there is a good case for clinical psychologists to be employed in primary care. As discussed above, GPs may not be screening mental health problems accurately. Clinical psychologists could assist in the screening, detection and assessment of mental health problems (BPS, 1998).

Evidence suggests that collaborative care involving GPs and psychologists can produce significant gains in patient's mental health. In NSW, Australia, Vines et al. (2004) conducted a cohort study of 276 general practice patients with

mental health problems receiving collaborative care from clinical psychologists and GPs, compared with a normative sample of 198 patients attending the same general practice surgeries. The intervention used was six sessions with the clinical psychologist, who used these sessions to conduct a full assessment, case formulation and then went on to deliver a focused psychological intervention which was predominantly CBT. The intervention group improved after treatment on all measures used (Depression, Anxiety and Stress Scales and the General Health Questionnaire) and did not differ significantly from the control group. The authors note that in addition to the positive effect of this collaboration for patients, it could also help to reduce the pressure on GPs who already have a substantial workload. I feel that although this does indeed reflect positively on the use of clinical psychologists in primary care, one of the problems in this study was that referral to the psychologist required the GP to make a decision on the patients current mental health. This could be problematic, as highlighted in the discussion above. However, by training GPs on the assessment and screening of mental health problems, clinical psychologists could assist GPs with this important issue. In general though, the results of this study do seem to indicate the positive effect of collaboration between GPs and clinical psychologists in primary care. I feel that it would be a useful model that could be part of general guidelines for primary care services in the UK. In the next section, I would like to discuss the therapy that clinical psychologists might deliver in primary care.

THERAPY DELIVERED BY CLINICAL PSYCHOLOGISTS IN PRIMARY CARE

Treating mental health problems in primary care is a less stigmatizing location to secondary mental health care (e.g. Nolan and Badger, 2002). Therefore mental health problems that respond well to psychological intervention within primary care can be treated in a less stigmatizing environment. Traditionally within

primary care there has been an overemphasis on GPs prescribing medication to treat mental health problems. For example, Rogers and Pilgrim (2001) discuss the history of prescribing minor tranquillisers for anxiety and depression during the 1970's and 1980's. As awareness in the community grew about these drugs and their potential side effects, people began to feel that GPs had been complacent with their care of these problems. They feel that the gap in care left by the non-prescription of these drugs began to be filled by the use of counselling in primary care and by alternative drugs such as Prozac. Given this backdrop, it seems that people want to receive talking treatments for mental health problems.

One of the most common therapeutic interventions used by clinical psychologists is CBT. France and Robson (1997) note that since 1972 clinical psychologists have become more involved in primary care, bringing CBT into many surgeries and health centres. Some of their key points about CBT include its methods being based on research evidence, treatment that is aimed at explicit, clearly defined goals and the use of 'tailor made' descriptions of problems rather than diagnoses which can be unhelpful or at worst misleading. They also highlight the fact that the patient collaborates as fully as possible in assessment, hypothesis creation and treatment. They felt that although CBT does not always provide solutions to the problems seen in primary care, it fits into primary care well because problems can be defined and conceptualized in operational and functional terms. Presumably these criteria are well suited to primary care because of the relatively short amount of time available to provide treatment. For example, in the Vines et al (2004) study above, only six sessions were provided by the clinical psychologist. I feel that the key points above emphasise the practical nature of CBT. In addition, the collaboration with the patient and reduced focus on diagnosis are very different to the traditional consultation with a GP.

Bibliotherapy, where psychologists advise clients on self-help literature, is also suited to the time constraints in primary care. For example, Frude (2004)

notes that there are good results for its effectiveness and it also enables psychological help to be delivered to people with mild or moderate mental health problems who would have to wait a substantial amount of time before they could meet with a psychologist. Other research has focused on the best treatment for specific mental health problems. For instance, CBT and interpersonal therapy are first choice for the treatment of depressive disorders, with behavioural therapy, problem solving therapy, group therapy, systemic therapy, non-directive counselling and psychodynamic interpersonal therapy also showing some evidence of effectiveness (DOH, 2001). In addition, patient choice is an important factor in determining therapeutic outcomes from therapy. For example, failure to take account of patient preferences on treatment type, length and therapist may damage commitment to the therapy (DOH, 2001). Because clinical psychologists have a broad training, they are in a good position to be able to offer this choice. Therefore, locating clinical psychologists within primary care has therapeutic benefits for the client and meets the guidelines laid out in standard two of the NSF. This is because they can identify and assess clients' mental health needs and offer them effective treatments. However, although the therapeutic flexibility of clinical psychologists makes them an asset to primary care, there is still the question whether counsellors could play a similar role. To consider this question I will discuss two papers by Ward et al. (2000) and Bower et al. (2000) investigating treatments in primary care.

RESEARCH ON THERAPY IN PRIMARY CARE

Ward et al. (2000) conducted a study to investigate the effectiveness of treatments for depression or mixed anxiety and depression in 464 general practice patients. There was a control group of usual GP care and two treatment groups, non-directive counselling or CBT from a clinical psychologist. The results

showed that after 4 months, patients recovered more quickly when referred to either treatment group, rather than remaining in GP care. However, at 12 months the GP care group had made up this difference. The results also showed that both counselling and CBT were equally effective.

Although this study demonstrates that CBT is effective in treating depression and mixed anxiety and depression, it does not present a strong case for using psychologists over counsellors. However, Bower et al. (2000) found no significant difference in the cost for the three treatment groups. This was on three levels: direct cost to health services, cost in terms of lost productivity and cost to society. The greatest cost benefit was found in the first 4 months, especially with CBT where this seemed to be more cost effective than standard GP care. However, any cost benefits at 4 months had evened out by the end of the 12 month study period.

The general conclusions from these two papers are that although CBT is effective for the treatment of depression and mixed anxiety with depression, non-directive counselling also seems to be equally effective. The use of CBT by clinical psychologists was more cost effective over 4 months, but because the difference had disappeared by 12 months there seemed to be no overall cost gain from the use of CBT. Given this result, it could be argued that in terms of therapeutic outcomes there would be equal gains for primary care services whether clinical psychologists or non-directive counsellors were employed there. However, a more recent study by Vines et al. (2004), which I reviewed above, found positive effects of CBT over GP care. Also, given that there was no difference in costs, by considering factors other than their therapeutic role, the case for employing clinical psychologists in primary care becomes stronger, as I shall discuss in the next section.

HOW CLINICAL PSYCHOLOGISTS CAN CONTRIBUTE TO THE ATTAINMENT OF NSF GUIDELINES

From the review of evidence presented thus far it seems that there are still questions surrounding the employment of clinical psychologists as therapists in primary care. Although research has demonstrated the positive effects of their therapy and collaboration with GPs, it could be argued that employing counsellors is equally effective. Although more research is required, I feel that there are still important gains for primary care services through employing clinical psychologists. In terms of cost savings, the Bower et al. (2000) study above found no cost gains from using CBT. However, other sources do indicate substantial cost savings from referral to clinical psychology. Papworth (2000) found that referral to a CMHT might cost over £1000, but referral to a clinical psychologist in primary care cost £140.

Clinical psychologists are an effective resource in primary care because of their use in consultancy, training and supervision (e.g. BPS, 1998). Their consultancy role with primary care workers takes place at various levels, from informal meetings over lunch to being able to make immediate consultations when they are required (Marzillier, 1999). By training other professionals in the primary care team in the use of psychological approaches, the availability of psychological care is extended (BPS, 1998). Strachan, Gibson and Deans (2003) describe an innovative method of providing psychological resources to GPs. They developed an intranet site providing self-help materials for download and guidelines on referral to the psychology service, which many GPs found helpful. Clinical psychologists' skills in supervision enable patients to receive care that is psychologically informed, even though it is not delivered directly by a clinical psychologist. This has added importance because there is often a shortage of

clinical psychologists in primary care and long waiting lists to see them (e.g. Papworth, 2000).

It is worth noting here that recent proposals for meeting the demands of mental health care within primary care have included the recruitment of psychology graduates to work as Primary Care Workers (e.g. Walters and Tylee, 2002). These workers would be recruited to provide brief therapies of proven effectiveness to those whose mental health problems do not seem to require more intensive care provided by Community Mental Health Teams. However, although Walters and Tylee (2002) welcomed the recruitment of these workers, they acknowledged that they will have supervision needs. If clinical psychologists supervised them, this would ensure that their practice was well informed.

Clinical psychologists can enhance primary care services through their skills in audit and research (e.g. BPS, 1998). Their audit skills would be useful in a number of ways, including monitoring patients' psychological well-being and satisfaction with services. For example, Ryan-Morgan et al. (2004) describe how the clinical effectiveness of a brief intervention therapy service in primary care was measured using standardised evaluation, audit and outcome systems for psychological therapies. Clinical psychologists' research skills could help shape the development of primary care mental health services. This could include developing screening assessments and referral processes to enable GPs to detect mental health problems more efficiently. For example, Shepherd (2003) discussed how referral criteria were developed for a primary care psychology and counselling service that involved the collaboration of psychologists, counsellors and GPs. By using a collaborative approach, she felt that professionals did not feel that they were having referral criteria externally imposed on them. The guidelines that they developed were found to be useful to both psychologists and counsellors when new to posts and when responding to inappropriate referrals. In addition, practices kept the referral criteria in their consulting rooms and the Primary Care Group incorporated the criteria into the counselling service

specification. It seems that this work would meet the NSF standard two because it would facilitate the identification and assessment of mental health problems and enhance the quality of primary care services through greater accuracy of detection. It would also ensure that therapy resources are used effectively. In this section I have summarised how clinical psychology can enable services to monitor their care standards and ensure their practice meets NSF guidelines. I would like to draw together some of the arguments for using clinical psychology in the next section, including discussion of the use of counselling.

FUTURE PRIMARY MENTAL HEALTH CARE SERVICES

I have outlined above research supporting the therapy and skills that clinical psychologists can bring to primary mental health care services. Another important theme has been the consideration of counsellors in primary care. From the review above, I would agree with Frude (2004, p8) that it would be hard to 'contend that either approach outstrips the other across the diagnostic board in terms of effectiveness'. However, I hope to have demonstrated that psychologist's additional skills are an asset that warrants inclusion in future primary mental health care services. I also feel that there are some important differences between counselling and psychology concerning regulation and training that may influence decisions to purchase psychological services instead of counselling. For example, Neary (2002) notes that not all practice counsellors belong to a professional body. Therefore, there may be issues concerning whether some counsellors meet professional standards and the quality of care that they may provide. The BPS (1998) notes that service providers must employ chartered clinical psychologists to ensure that they adhere to professional and ethical guidelines. Having one governing body makes it clearer to see the regulations governing clinical psychologists over counsellors. Other authors have

raised concerns over primary care counselling because it is cheaper for GPs to implement. For example, Rogers and Pilgrim (2001) felt counselling could become a disposal route for those with psycho-social needs but may not meet more complex needs. Obviously this view is more favourable towards the broader training of clinical psychologists, who would have greater resources to meet more complex needs. Perhaps psychology needs to state its claim over the right to be involved in primary care services in the future, particularly with the agenda for change on the horizon. However, my personal view is that we should be looking to work more closely with counsellors, for example in the manner outlined by Shepherd (2003) above. Other ways that we could work with counsellors include training them in psychologically informed therapies and providing supervision to them.

For clinical psychologists I feel that there are still some issues that need to be clarified concerning the organisation of primary care services. It may be the case that a shortage of clinical psychologists in primary care has resulted in secondary care psychologists conducting primary care work. This may be contributing to some of the confusion that can be experienced by clinical psychologists working on the interface between primary and secondary care. There is a need for clear models of service delivery, such as primary care teams, which could eliminate the confusion currently experienced by some clinical psychologists. As Walters and Tylee (2002) note, there is an important need for primary and secondary care professionals to take on new roles that challenge the traditional model of a GP as gatekeeper to mental health services. I feel that some of the skills outlined above demonstrate how clinical psychologists would be well placed to take up this challenge.

Finally, I would like to give some consideration to the agenda for change and how this could impact on primary care services. This topic was discussed at the North Essex Psychology Department Away Day on 1.12.04. The agenda for change is set to make clinical psychology services become more expensive as

we can command greater salaries. This may make us seem less attractive to service commissioners, especially because there may be cheaper options available including counsellors and primary care workers. Similar points to this have already been made by Rogers and Pilgrim (2001) who note that clinical psychology is in a contradictory stage of development or decline. They felt that problems for psychology include cheaper treatment packages being offered by other modalities, such as counsellors and their role being eroded by other professionals. Given these warnings, it will become imperative in the future for clinical psychologists in primary care to be able to make a strong case for their own employment. It is feasible that in the future psychologists will be required to take on more supervision and managerial roles to suit their greater salaries. Generally, I hope that I have outlined above some of the arguments to support their employment in future primary mental health care services.

CONCLUSION

In this essay I have outlined the NSF, defined primary care and discussed the work of counsellors and clinical psychologists in primary care services. I have discussed the need to develop a clear model for primary care services and how evidence supports a collaborative model between clinical psychologists and GPs. I have looked at research evaluating the treatment clinical psychologists provide and research comparing counselling to clinical psychology. I have discussed how clinical psychologist's therapeutic interventions meet the NSF and how they can also meet NSF guidelines through their other roles. In terms of therapy provision, research does not clearly advocate the use of clinical psychology over counselling. However, I have discussed additional benefits to employing clinical psychologists in primary care. Based on research to date, I feel that the broad

training and skills of psychologists, both therapeutic and otherwise, will make them an asset to future primary care services.

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Written Exercise 2

Discuss the construction of 'psychopathology' in
children and adolescents:

What can we learn from self-injury?

Introduction

Psychopathology is 'the scientific study of mental disorders' (Oxford English Dictionary, 2006). In medicine 'disorder' means 'a disruption of normal physical and mental functions' (OED, 2006). I chose to write about self-injury following my work with an adolescent girl who had a history of self-injury. Self-injury can be a feature of a number of different diagnoses, including a range of personality disorders, schizophrenia, major depression, mania, OCD and hypochondriasis (Gardner, 2001). The adolescent girl's self-injury had not been viewed as severe enough to warrant assessment from a consultant psychiatrist and therefore she did not have a diagnosis. I became interested in the role of diagnosis in self-injury. I wondered whether self-injury was always viewed as psychopathology and if it is ever possible to view self-injury as a behaviour that is not psychopathological.

The construction of self-injury in children and adolescents who have a learning disability is beyond the scope of this essay. Childhood self-injury research is dominated by this work (at the time of writing the PsychInfo database revealed 83 of the first 100 childhood self-injury articles were on learning disability). However I will consider how childhood experiences in non-learning disabled children may lead to self-injury in adolescence. I will begin the essay with a definition of self-injury. I will then outline biological, psychological and social models that attempt to explain self-injury. These models can influence how self-injury is viewed and can facilitate the de-construction of self-injury. They can also help us to consider more generally how psychopathology is constructed. I shall contrast these models to the medical model and advocate the use of a bio-psycho-social model that facilitates our understanding of child and adolescent behaviour (see for example Cook et al., 2005). I shall outline the effectiveness of

the bio-psycho-social model when applied to the childhood origins of self-injury in people who have experienced childhood sexual abuse (CSA). Discussion of CSA highlights developmental issues linked to self-injury. I hope to highlight some of the challenges inherent in our conceptualisation of psychopathology in young people when I consider service-users' views and discuss my own experiences of therapy with an adolescent girl. I shall then discuss my own views on self-injury and the pros and cons of viewing it as a sign of psychopathology. This essay will finish with a summary and conclusions.

Defining Self-injury

For the purpose of this essay, self-injury will be defined as:

‘...An act which involves deliberately inflicting pain and / or injury to one’s own body, but without suicidal intent. The most common form of self-injury is cutting, often of the arms and hands...’ (Babiker and Arnold, 1997, p2)

These authors, as do many others (e.g. Favazza, 1998, Connors, 2000), distinguish self-injury from other similar behaviours. These may include other self-destructive behaviours such as eating disorders and substance abuse. Hawton and James (2006), report that some 7-14% of adolescents will self-injure at some time in their life. It is important to emphasise the difference between self-injury and suicidal behaviour. The literature often does not make this important distinction clear. For example, the National Institute for Clinical Excellence (NICE) guideline defines self-harm as ‘self-poisoning or injury, irrespective of the purpose of the act’ (NICE, 2004). This puts together behaviours that may be attempted suicide with behaviour that has no suicidal intent. Babiker and Arnold (1997), note that in attempted suicide the intent is to die, but this is not the case in self-injury. They also state that the pain and despair experienced in both

behaviours may be equivalent. In this essay, I shall consider whether inflicting pain or injury to ones own body should be considered as a behaviour that reflects a mental health problem or psychopathology. In order to do this I will begin by reviewing biological, psychological and social models of self-injury.

Models of self-injury

Biological Models

Biological models of self-injury take the view that individuals self-injure because of a chemical imbalance in the brain. For example, Winchel and Stanley (1991) note that painful stimulation releases endorphins. One possible biological mechanism for self-injury is that the opiate system of some individuals may be altered so that the natural opiates level is too low. Through self-injury, opiates would be released to maintain adequate levels of endogenous opiates. However, Grossman and Siever (2001) note that studying these mechanisms in self-injury is difficult given the heterogeneous nature of these problems and the wide range of definitions and diagnoses that may be linked to self-injury. In their review of evidence, they felt that serotonergic pathways and endogenous opiates may be involved in self-injury. However, they stated that at present the role of the biology and pharmacology of self-injury is remarkably understudied. Therefore, although self-injury may be maintained by the release of endorphins, biological models cannot fully explain the phenomena. I believe that psychological models may enhance understanding of the causal factors linked to self-injury.

Psychological Models

Psychological models can be used to consider self-injury from an individual's perspective. For example, Cognitive Behaviour Therapy (CBT) considers the affect of unhelpful thoughts, feelings and behaviour in the development and maintenance of self-injury (e.g. Stallard, 2005). The CBT model would not

exclude a role for the biological factors noted above. However they add to our understanding by including psychological factors that can affect our behaviour. If psychological models are an accurate and useful conceptualisation of self-injury then they should also inform the treatment of self-injury. However, at present, evidence for the efficacy of psychological treatments of self-injury is still under-researched. For example, Hawton et al. (1998), in a systematic review of randomised controlled trials found that although there are promising indications for both CBT and problem-solving therapy, there is still the need for further research into psychological treatment of self-injury. The Department of Health made similar conclusions in their paper *Treatment Choice in Psychological Therapies and Counselling* (DOH, 2001). For the purpose of this essay it is also important to note that this research is generally based on individual work conducted with people aged over 16. Research on treatment for cutting is omitted from the child version of 'What works for Whom?' (Fonagy, Target, Cottrell, Phillips and Kurtz, 2002). However, one paper with adolescents aged 12-16 found some promise with a group intervention for adolescents who self-harm that used methods from problem solving and CBT (Wood, Trainor, Rothwell, Moore and Harrington, 2001). Research suggests that CBT is a useful treatment for the underlying depression that can be a feature of self-injury (e.g. Hawton and James, 2005). However, Harrington (2001) notes that many adolescents who harm themselves have depressive symptoms but few have depressive disorders. In my opinion one of the most helpful aspects of psychological models is their use of formulation. Through consideration of explanatory models, formulation can lead to hypotheses of the causal and maintaining factors in self-injury and provide directions for treatment.

Psychological Models – Family

The importance of an individual's perspective and meaning making has been noted as important in psychological models of self-injury. Families may also have

a role in self-injury. For example, Webb (2002) in her literature review found that family factors such as problems in family relationships played an important role in whether an individual might engage in self-injury. Fox and Hawton (2004) felt that early familial life experiences including poverty, criminality and parental problems such as divorce were all risk factors for self-injury in later life. From a systemic perspective, it is also possible to view self-injury as serving functions for a whole family, rather than an individual (e.g. Babiker and Arnold, 1997). For example, one systemic idea I have encountered in my own experience is with a family where an adolescent girl self-injured. In this family, a systemic hypothesis of the girl's self-injury was that it kept the family together. This was because it enabled the family to focus on the girl's self-injury rather than to consider what it might be like for their mother to become less 'like a friend' and more 'like a mother' towards the family members.

Social Models

Babiker and Arnold (1997) review a number of social considerations that may have a causal role in self-injury and space constraints do not allow an extensive discussion of their views on social attitudes to age, disability, imprisonment and sexuality. Given that self-injury is most common in women (e.g. Whitlock, Powers and Eckenrode, 2006) I will briefly consider the issue of gender. In particular, the social pressure placed on women to conform to societal expectations about their weight, size and sexual attractiveness can provide a number of contexts for self-injury. For example, if a woman feels unsuccessful at work she may relate this to other physical attractiveness. Self-injury in this context may be a reflection of feeling unacceptable to other people. In this sense it is spoiling the very thing that society both values and despises (Babiker and Arnold, 1997).

From this brief review of models it is apparent that there are a number of ways of conceptualising self-injury. I would argue that no model on its own can adequately explain how self-injury occurs. However, the deconstruction of self-

injury using the models above can facilitate understanding of the causal and maintaining factors in self-injury. In the next section I will discuss ways of integrating the models and compare them to the medical model of diagnosis.

Medical model versus Bio-Psycho-Social Perspectives on Self-Injury

One useful way of understanding how self-injury is constructed is to explore the models above further. I will outline the role of the medical model in self-injury. Then I will suggest that an integration of the models above provides an alternative and more useful way to conceptualise self-injury. This is because they give greater consideration of the meaning of self-injury.

Medical Models

One of the most obvious manifestations of the medical model is the fourth edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM IV) (American Psychiatric Association, 1994). DSM IV is a diagnostic classification system that specifies the criteria that need to be present in order to make a diagnosis. Pattison and Kahan (1983) attempted to create a deliberate self-harm syndrome that had clinical characteristics that would distinguish it as a diagnosis that is separate from other types of problem behaviours. They proposed that it should be included in DSM IV, but at present deliberate self-injury is not categorised in DSM IV (Sutton, 2005).

The closest link to diagnosis and self-injury is shown in the common finding that people who self-injure will receive the Borderline Personality Disorder (BPD) diagnosis (e.g. Hawton, 1990, Warner, 2004). To receive this diagnosis according to DSM IV the client must meet five or more out of nine criteria (APA, 1994). It is criterion five that makes reference to self-injury, as in 'recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour'. In children and adolescents, BPD is characterised by the persistence of multiple neurotic

and behavioural problems that should have been outgrown (Kernberg, Weiner and Bardenstein, 2000). These behaviours rely on making a social judgement on acceptable behaviour, rather than objective scientific assessment. This is a problem with psychiatric diagnosis highlighted by Johnstone (2000). A related problem is that medical models are taken to indicate psychopathology. This fact has been criticised because focusing on pathology often neglects the meaning behind behaviour (e.g. Solomon and Farrand, 1996, Babiker and Arnold, 1997). In my opinion, self-injury is often interpreted as a reflection of BPD, when this may not necessarily be true. This has obvious implications for the treatment clients may receive, particularly when they are receiving treatment for their self-inflicted wounds. For example, some clients have found that staff regard them as 'time-wasters' or 'attention seekers', perhaps because the important personal function of their self-injury is not understood (e.g. Sutton, 2005, Mental Health Foundation, 2006).

Do bio-psycho-social models help us to understand how experiences in childhood and adolescence can lead to self-injury?

Adolescence is a time of great change in an individual's life. Cognitive and physical changes are taking place and mood swings are common (Harrington, 2001). It is possible these changes may provide a background context for self-injury to develop. Most of the research on the models above has been conducted in adult populations. It is important to consider more closely whether these models are relevant to childhood and adolescence. Murray, Warm and Fox (2005) have also noted this problem and added that because researchers frequently include suicide attempts in their research, it is difficult to build up a general picture of non-fatal self-harm in adolescents. They used an internet sampling technique to attempt to access young people who may not have been in touch with mental health professionals. In their sample of 128 respondents, 88% were female and the mean age was 16.7 years. The most frequent age when

self-injury began was 13 years old, however some respondents reported beginning as young as 5 and 8 years of age. Early experiences of sexual and physical abuse and psychological and behavioural experiences of eating disorders, alcohol problems and dissatisfaction with sexual attractiveness were prevalent in their sample. Another important issue related to sexuality was that a sizeable number were bisexual (22.7%). Generally they felt the results emphasised the need to explore issues of sexuality, sexual attractiveness and body satisfaction in relation to self-injury.

In my opinion, given the complexity of the issues in the Murray, Warm and Fox (2005) sample, bio-psycho-social models offer the most adequate model to help us to deconstruct self-injury. This also helps us to begin to understand the causation and maintenance of self-injury. I don't believe that the medical model is very useful in this circumstance for the reasons noted above. However, it also highlights the fact that at present we don't have clear information on the prevalence of self-injury in children and adolescents. Whitlock et al. (2006) felt that evidence suggested self-injury follows two distinct patterns. The first begins in childhood and persists through adulthood. The second emerges in adolescence and declines in late adolescence or early adulthood. More research is required on how biological, psychological and social factors influence the course of these patterns of self-injury.

Application of the bio-psycho-social model to childhood - The example of Childhood Sexual Abuse (CSA)

One example of how bio-psycho-social models may facilitate our understanding is in CSA. A dominant theme in the self-injury literature is that traumatic experiences in childhood, including CSA, can lead to self-injury in later life (e.g. Favazza, 1998, van der Kolk, Perry and Lewis-Herman, 1991, Evren and Evren, 2004). It has been hypothesised that CSA has a psychological and biological impact on developing children. For example, van der Kolk et al. (1991) felt that

psychological maintaining factors could be a lack of secure attachments and biological maintaining factors could be linked to the immaturity of the central nervous system of children. This would make children more vulnerable to flawed biological self-regulation following CSA. They also noted the possible role of hormones in dissociation and impulsive behaviour that would be triggered by reminders of earlier trauma and abandonment. Other research on CSA includes that of Parker et al. (2005). They noted that it is still unclear whether CSA leads directly to self-injury or whether it is via some impact on personality development. They felt that poor impulse control and using externalising behaviours to manage stress during childhood could perhaps increase the likelihood of self-injurious behaviour in later life. They felt that determinants of self-injury were likely to reflect multiple genetic and environmental factors that would be influenced by abusive experiences in childhood. They noted that many people who experience childhood deprivation do not self-injure. In my opinion bio-psycho-social models of CSA and its relationship to self-injury enable us to consider self-injury from a developmental perspective. They emphasise how early childhood experiences can impact on a child's biological and psychological development in a more comprehensive manner than the medical model.

Young people's views on self-injury

I have reviewed evidence supporting the use of models in beginning to help us to conceptualise self-injury in childhood and adolescence. Models have an influence on how self-injury is constructed and related to psychopathology. However, it is also important to consider the views of people who self-injure on what the causes and maintaining factors might be in self-injury. Their views may also assist in our deconstruction of self-injury in the same manner that the models above have done. For example, some young people who self-injure do not view their behaviour as a problem (e.g. Evans, Hawton and Rodham, 2005). In their review

of 6020 15-16 year old school pupils they found that the majority of those who had self-injured had indicated they had serious personal, emotional, behavioural or mental health problems in this period. However, 25% of adolescents who self-injured did not think that they had a serious problem and 40% had not talked to or tried to get help from anyone. From the Evans et al. (2005) study it appears that although young people often don't believe they have a problem, it is likely that they have serious psychological problems. In contrast, Spandler (1996) conducted interviews with 10 young people who self-injured. Young people described self injury as 'getting rid of unwanted and distressing feelings and emotions' and 'focusing or transferring emotional pain onto a physical, more manageable and tangible thing'. Spandler's study emphasises that it is possible to conceptualise self-injury without using the language of diagnosis or disorder. Sellen (2006) found that service users were often concerned about how mental health staff would view their problems and whether staff would ever be able to understand what self-injury really meant. In my opinion bio-psycho-social models of self-injury do help us understand what self-injury means for an individual. Research suggests that sometimes self-injury may reflect serious underlying problems, but at other times it may not be conceived as a problem. I believe that bio-psycho-social models assist in the arbitration over whether self-injury should be viewed as a problem or not. This is because they consider all the factors involved in an individual's self-injury. I would like to emphasise this by my own experiences with a client who had self-injured.

Case example – my work with Jennifer

Between May 2006 and July 2006 I saw a 14 year old girl for seven sessions of individual therapy. I shall call the girl Jennifer for the purpose of this essay. I would like to write about Jennifer to emphasise some of the difficulties I had with thinking about whether self-injury reflects underlying mental health problems.

Background History

Jennifer lived with her mother and father who had been married for 30 years. Her mother was a teacher and her father was a dentist. She had two older sisters, aged 26 and 23. Because her sisters were much older she had been raised like an only child and her parents had told Jennifer that she wasn't planned. Jennifer reported being bullied at school for two years prior to starting high school. She said this had left her with low self-esteem. When she was first referred she reported being unable to talk to her family about her problems and concerns. She noted that she had been self-injuring for about a year before her mother and sister discovered evidence of her self-injury. Jennifer's self-injury had included cutting her arms and legs with sharp implements and burning herself on her arms. When her self-injury was discovered, she was taken to her GP who referred her to the service.

Initial Assessment

Jennifer had extensive scars on her forearms and it emerged that her last episode of self-injury had been approximately two months ago. She did not currently feel a need to self-injure and also stated that she had never felt suicidal or had suicidal thoughts. We began to think about what happened prior to an episode where she would self-injure. I used this information to inform the CBT part of the formulation below. A notable incident reported during the initial assessment concerned Jennifer's mother. Two weeks prior to her first self-injury her mother was hung-over one afternoon and fainted. She smashed her head on the oven door and required hospitalisation. Jennifer had been upstairs when the incident happened. When her father returned from work he found her mother unconscious on the kitchen floor. Her father called her down to help attend to her mother. She described wiping her mother's blood off her hands and being very worried about her mother.

Brief Formulation

Jennifer noted that a pattern seemed to take place before episodes of self-injury. Her mood would become lower in a 'downward spiral' a few hours before self-injury. She would begin to have negative thoughts about herself, such as 'I am worthless' or 'nobody cares for me'. I felt this was linked to her early experience of being told by her parents that she was unplanned. I believe that Jennifer interpreted this as being 'unwanted'. As her mood began to spiral downwards, she described becoming lost in her thoughts, almost as if she wasn't aware of them any longer. This may have been like dissociating from her thoughts. During this process she would feel the need to self-injure in order to alleviate the distress caused by her low mood. She reported that when she took a sharp implement in her hand and when she cut herself, both of these acts did not feel in full conscious awareness. However, she reported feeling relief after self-injury and that she would begin to feel more 'in tune' with her thoughts after self-injury had taken place. I felt that a CBT model was helpful to think about what happened in each episode of self-injury. I thought that if I could help Jennifer to begin to pay more attention to her thoughts when her mood was low, she might be able to engage in alternative coping strategies before she began to lose track of her thoughts. When she was dissociating in this way, it increased the likelihood that she would self-injure.

Gardner's (2001) psychodynamic model of self-injury emphasises the importance of early relationships in a person's life and how traumatic experiences would be inwardly responded to by the act of self-injury. I felt this was important when considering what her mother's accident meant to her. I aimed to explore her relationship with her mother further in therapy.

Progress in Therapy

Using the CBT model helped us to think about Jennifer's cognitions as her mood entered the downward spiral. Through problem solving together, she was able to identify strategies that she could use to prevent her mood reaching the point of self-injury, such as phoning a friend to talk to them, playing the drums or drawing. It also emerged that self-injury was a coping strategy that her peers also used that was frequently discussed in her peer group. Among her peers, self-injury was acknowledged as far from ideal, but nonetheless it was an acceptable coping mechanism. During therapy Jennifer acknowledged that during the time she was self-injuring she had no friends and felt very low. However, since starting high school she had been able to make a group of friends who she felt close to. She noted that bullying was less of an issue to her now. In the second session she talked about coming out as a lesbian to her friends who were very supportive. Jennifer was able to spend time in therapy talking about whether to tell her parents and family about her sexuality too. After six sessions, Jennifer did not attend therapy for four weeks. I had one final session, with part of the session with her mother present, to review the therapy. Jennifer had found it useful to talk about what led to her period of self-injury. However, she now had good friendships and gained a lot of support from her friends. She felt that therapy was no longer relevant or useful to her. She had also been able to come out to her mother and sisters, which gave her a great sense of relief.

Does self-injury indicate that a young person has psychopathology?

My feeling is that self-injury for Jennifer was very much a coping mechanism during a stressful period in her life. Although she reported low mood in the past, I am unsure whether her low mood would have met criteria for clinical depression. Apart from the fact that she had self-injured, I didn't feel that there were any other presenting symptoms that were indicative of underlying psychopathology. I don't

believe that she was suffering from a mental disorder and although self-injury may have been detrimental to her quality of life, she was still getting on with many aspects of her life as usual. I believe that Jennifer's self-injury followed the second pattern noted by Whitlock et al. (2006) of beginning in adolescence and discontinuing in adolescence. Therefore, in my opinion, it is possible to view self-injury as a behaviour that does not indicate a person has a mental health problem.

If Jennifer's low mood was more severe, or if her self-injury had been more severe, then I think it would have been appropriate to seek a diagnosis of her problems. As noted above, the diagnosis would not have been 'self-injury', because this does not exist as a diagnostic category. However, a diagnosis would have been a reflection of additional symptoms that Jennifer presented with. Under these circumstances a diagnosis may have ensured that she had access to appropriate services or helped both Jennifer and her family to understand more about her problems. Although diagnosis did not seem relevant to her presentation, the use of psychological models and formulation enabled me to arrive at this conclusion and a successful outcome. Therefore, although I conceived Jennifer's self-injury as a problem, I don't believe that it represented psychopathology. Jennifer also appeared to have no need for therapy and able to find support in peer relationships. This raises the question over who defines what a problem is (e.g. Johnstone, 2000). In this case, I think that Jennifer did view her previous self-injury as a problem, but perhaps within an acceptable or normal range of coping responses. I don't think that she would have viewed self-injury as a current problem. Although I felt that Jennifer may have benefited from exploration of some of her relationships, I don't believe this was essential in order to prevent future self-injury. It is likely that she may explore some of these relationship issues with her peers in a more helpful way than discussing them in therapy. Therefore although therapy may be helpful, I agree with Evans et al.

(2005) that the most useful intervention in self-injury would be to teach school pupils how to improve the quality of the support that they can offer each other.

Although it would be unhelpful to conceptualise Jennifer's problems as pathological there could clearly be cases where self-injury might be viewed in this way. This illustrates the complexity of constructing psychopathology. In Jennifer's case, if one constructed her self-injury in diagnostic terms and viewed it as pathological then the intervention may have been unhelpful. I think that in practice balancing our views between behaviour that is pathological versus behaviour that is non-pathological is hard to achieve. With regard to self-injury, there are a number of concerns in viewing it as behaviour within the normal range of adolescents' experiences. For example, Whitlock et al. (2006) have raised concerns that although self-injury internet forums provide support for otherwise isolated adolescents, they may also normalise and encourage self-injury and add potentially lethal behaviours to adolescents' repertoires of behaviours. Another cautionary note comes from Fortune (2006). She found evidence to suggest that anecdotal reports that self-injury has nothing to do with suicidal behaviour are misleading. These concerns emphasize the importance of formulation from an individual's perspective and putting in place appropriate risk reduction strategies if they are required. In my experience using clinical diagnosis can bring relief to families of young people because it can provide a framework to help them to understand their child's behaviour. It requires sound clinical judgement to determine whether to use diagnosis against behaviour that may be within the limits of social acceptability.

Summary and Conclusions

In my opinion, self-injury as a behaviour in its own right may not always be indicative of psychopathology. I believe that this reflects the confusion that can be present when conceptualising whether problems in children and adolescents

reflect underlying psychopathology. I believe this is why previous attempts to classify it as a diagnosis have only had limited success (e.g. Pattison and Kahan, 1983). As noted by Harrington (2001), defining the boundary between extremes of normal behaviour and psychopathology is a dilemma that pervades all of psychiatry. This is certainly true when we consider self-injury. In my review of models of self-injury I felt that an integration of models was required to enhance our understanding of self-injury because one model alone could not adequately explain the phenomena. In my opinion this multi-model, bio-psycho-social approach is important when conceptualising psychopathology in children and adolescents. In particular I believe that this approach reduces the need for the medical model approach. The medical model can often conceptualise problems as pathological to the detriment of focusing on the meaning of behaviours.

People with mental health problems can face stigma and therefore reducing the use of medical models can be helpful for children and young people. We are still able to offer supportive services to these individuals without using labels that indicate mental disorder. In my experience, using formulation removed the need to pathologise self-injury or to seek a diagnosis unnecessarily. I don't think that this removes the need for diagnosis altogether. If Jennifer's problems had been more severe, then I feel that it would have been appropriate to seek a diagnosis. However, I also believe that if we can avoid moving into diagnosis too quickly, this can remove the potential for stigmatising young people who self-injure. A number of approaches to conceptualising self-injury have been outlined above. However we still don't fully understand what brings young people to self-injure. I believe that self-injury provides an example where using formulation to conceptualise problems rather than pathological labels is most helpful to clients. Perhaps this conceptualisation can be usefully applied to other disorders as well.

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Small Scale Service Related Project

An Audit of an Adult Mental Health Family Therapy Clinic

Abstract

This study examined all referrals to an adult mental health family therapy clinic received between September 2000 and September 2004. A total of 71 referrals were received with 29 clients completing two or more therapy sessions. The average wait time for the first appointment was 162 days. There was no significant difference in wait time or age between clients who did and did not receive therapy. The average amount of time spent in therapy was 325 days. For clients who received therapy, the rate of positive symptom outcome was 59% and the rate of positive systemic outcome was 59%. These results compared favourably with a previous audit of the service and other published family therapy audits.

Introduction

The evidence base for family therapy

A number of recent documents from the Department of Health (DOH) promote the use of family therapy when treating adults with mental health problems. Treatment Choice in Psychological Therapy and Counselling (DOH, 2001) defines family therapists as follows:

'Systemic and family therapists understand individual problems by considering the relevance of family relationships and the impact of the wider social and economic context on people's lives, their well being and their mental health' (p8)

The document notes the importance of psychological therapy in treating mental health problems. Family therapy is recommended as a treatment of choice in anorexia nervosa (p25) and for depressed people who are also experiencing marriage problems (p30). The National Service Framework for Mental Health (NSF) (DOH, 1999) promotes the use of family therapy with people who have psychosis, noting that family therapy combined with medication can prevent relapse and reduce admission to hospital for patients with schizophrenia (p46). The National Institute for Clinical Excellence (NICE) guideline for the treatment and management of schizophrenia in primary and secondary care (NICE, 2002) recommends interventions with the families of people with schizophrenia (p13). However, a more mixed result can be found in The Cochrane Review of family therapy treatment for schizophrenia by Pharoah et al. (2003). The authors felt that firm conclusions could not be made without further controlled trials in the use of family therapy with people who have schizophrenia.

A number of reviews have provided support for the use of family therapy across mental health problems. For example, Markus et al. (1990) in a meta-analysis including 19 studies found that the average patient with family therapy is better off than 76% of patients with an alternative treatment, a minimal treatment or no treatment. Shadish et al. (1993) conducted a meta-analysis of 163 randomised trials of marital and family therapies and found that clients receiving these types of therapy had more improved outcomes when compared with control clients. Asen (2002) reviewed controlled trial family therapy research with adults and found evidence supporting its use in eating disorders, psychosis and mood disorders. Shadish and Baldwin (2003) conducted a meta-analysis of 140 meta-analyses in psychotherapy (i.e. a meta meta-analysis). They found that family therapy is clearly efficacious when compared to no treatment, that it is as least as efficacious as other modalities such as individual therapy and that there was little evidence for differential efficacy among the various approaches within family therapy interventions.

This brief review leads to discussion about the types of evidence used to evaluate family therapy. For example, Stratton (2005) has noted that there is evidence from a number of sources supporting the use of family therapy. These include formal evidence from controlled trials where a specific type of therapy is used with clients who have a specific diagnosis to less formal studies which may be more like those seen in everyday clinical practice. Lerner (2004) has noted that there is a strong political motivation to find evidence-based status for family therapy so that it can enter more mainstream areas of therapy and mental health practice. However, he argues that as a discipline it does not easily fit manualised and controlled studies.

Previous audits of family therapy services

The summary above indicates that there is now substantial evidence for the efficacy and effectiveness of family therapy (e.g. Stratton, 2005). This brings us

to a different source of data, clinical audit. Conducting a clinical audit can address some of the issues raised by Lerner (2004) and Stratton (2005), including evaluating whether the evidence from controlled studies translates into what is happening in the real world clinic and attempting to find out what it is about the relationships between client and therapist that makes family therapy successful. It may also add more detail to existing evidence, such as which diagnostic groups are most likely to benefit from therapy and what type of family therapy is most useful for a particular diagnostic group. Another important consideration when evaluating family therapy is the notion of first and second order change (e.g. Stevenson, 1993). First order change refers to symptom improvement and second order change refers to change in how the family relationships are organised or structured in relation to the problem. Stevenson (1993) notes that there is some controversy over whether the two forms of change are related, with some research groups arguing that first order change is adequate for therapy, although second order change should still be evaluated.

Before describing the current study I shall briefly review two published family therapy audits. Chase and Holmes (1990) conducted a two year audit of 34 families attending an adult psychiatry family therapy clinic. They focused on the relationship between diagnosis and outcome. They found that families receiving between four and ten sessions had the best outcome and that improvement was generally maintained at two year follow-up. In addition, patients with affective disorders and eating disorders had good outcomes. In terms of first order and second order change, second order change could occur in families with a psychotic member, even though the first order symptoms might not change. Bloch, Sharpe and Allman (1991) studied the first 50 families to attend an adult psychiatry family therapy clinic. They noted the importance of audit as a 'nuts and bolts' descriptive exercise, due to the small number of published reports on family therapy clinics. They found that 18 identified patients were 'much better', 16 were 'better' and 14 had 'no change', with 2 'worse' than when therapy began. In

relation to the family, or second order change, 14 families were 'much better', 12 families were 'better', 23 had 'no change' and 1 family was 'worse' than when therapy began. In summary, at least half the identified patients had improved and at least half of the families had improved following therapy.

The current audit

This study will employ a similar method to the two previous audits described above where therapy team members independently rate change in symptoms following therapy. However, the previous studies employed a five point rating scale where therapists would rate the improvement in symptoms following therapy ranging from 'much worse' to 'much better'. Following discussion with the therapists who would be conducting the ratings in the present study, it was agreed that a more conservative 'change' or 'no change' rating would be used to maximise the reliability of the rating.

The family therapy clinic was situated in an adult mental health service in the south east of England. Two qualified systemic therapists (one was also a clinical psychologist) were the permanent members of staff. In addition, the team was completed by a number of other professionals including trainee clinical psychologists and other professionals at various stages in their professional training. The team met for two sessions per week, each of four hours duration. This allowed four families to be seen each week. The team members all worked in local community mental health teams and were well known to potential referrers. The therapeutic style of the therapists was systemic. A typical session would begin with the family therapy team reviewing the case notes. Then a member of the team would meet with the family for approximately 50 minutes, with the rest of the team observing the session in an adjacent room via a video camera linked to a television screen. After 50 minutes, there would be a break of approximately 10 minutes where the therapist would leave the therapy room to meet with the observing team. Following the meeting, the therapist would return

to the family for a short period of time and present closing comments from the team that had been discussed during the break.

The family therapy clinic had been in operation since September 1996 and been subject to an audit in March 2000. The previous audit report of the first 37 referrals was unpublished and found that 25 families (68%) attended for one or more sessions and 12 families (32%) did not attend for any sessions. The 'change' and 'no change' rating used to measure outcome was a combined consideration of both the first order and second order change within the client and family. The results found that 9 families (24%) had changed, 8 families (22%) showed no change, 8 families (22%) dropped out from therapy once it had commenced and 12 families (32%) did not attend any for any sessions.

A notable difference in the current audit concerns the level of training of the therapists. In the previous study, the therapists completed their training during the audit period. Therefore, the current study represents a time frame where the therapists had been fully qualified and also had greater clinical experience. This study will improve on the previous audit by recording both first order and second order change. In addition, this study aimed to improve the previous audit by including a client satisfaction survey to obtain clients views of the clinic. This study aimed to contribute to the audit cycle by comparing the results to the previous audit.

Audit Questions

1. How many referrals were there to the family therapy clinic between September 2000 and September 2004?
2. Who did these referrals come from?
3. How many inappropriate referrals were received?
4. What is the waiting time for therapy?
5. What are the diagnosis and demographic features of the referrals?
6. What are the systemic issues for clients receiving therapy?

7. What is the average number of therapy sessions?
8. What is the symptom outcome for clients receiving therapy?
9. What is the systemic outcome for the families of clients receiving therapy?
10. Does the outcome relate to the diagnosis, number of sessions or waiting time?
11. Does therapy make a difference to use of other mental health services?
12. How satisfied are clients with the family therapy service?

Method

Approval for the study was obtained from the local Clinical Audit and Effectiveness Group.

Participants

By examining the family therapy clinic database all clients who were referred to the clinic from September 2000 to September 2004 were obtained.

Data Collection

Clinical notes and the trust computerised records system were examined to obtain the gender, age at time of referral, diagnosis and profession of the referrer for each client.

Data Grouping

The level of engagement was divided into three groups:

1. Therapy - Clients who were offered therapy and had completed their therapy during the audit time period. They had all attended a minimum of two therapy sessions.

2. Non-engaged or unsuitable - This group included clients who did not engage either because they were offered therapy but did not attend appointments or because they declined the offer of therapy. If these clients had been seen at the clinic, it was only for an initial assessment session. Clients who had attended an assessment but were assessed as inappropriate for therapy were also included in this group because by attending for one session they only had a limited engagement with the clinic.

3. Miscellaneous - This is a broad group that consisted of clients who had been removed from the waiting list, clients who were still in therapy at the end of the audit period, clients who had died, clients who had been assessed and were on the wait list, clients screened as inappropriate before assessment and clients who had moved out of the area. Because of the broad range of outcomes or inability to follow them up, no further analysis was conducted for this group.

Wait time

Wait time, defined as the time that elapsed between the date that the referral was received and the first appointment, was collected for clients apart from those who had moved out of the area and those screened out as inappropriate before being assessed.

Additional data collected for therapy group

The main group of interest was the therapy group. Clients in this group had more information available because they were known to the family therapy team. This enabled recording of the systemic problem in the family. The systemic problem was agreed by consensus between the two therapists. The number of therapy sessions and time span for therapy was also recorded. Each client's use of

mental health services was taken as an indicator of the level of support that they were requiring over a time period. Use of mental health services was obtained by recording their number of outpatients, community and day care appointments. The time periods of interest were the year prior to therapy commencing, the time during therapy and the year following therapy.

Outcome

All clients in the therapy group were given two outcome ratings, a systemic outcome and a symptom outcome. The systemic outcome had two possible ratings, neutral or positive change. Neutral meant that following therapy, there had been no change within the family. Positive meant that following therapy there had been improvement within the family or that the family had derived some benefit from attending therapy. The symptom outcome also had two possible ratings, neutral or positive. Neutral meant that there was no change in the client's symptoms following therapy. Positive meant that the client's symptoms had improved following therapy i.e. their symptoms caused them less distress following therapy.

Two clinicians rated the data. Each clinician blind rated the clients on the systemic and symptom ratings. When they did not agree, they had to discuss the family together to reach a consensus rating. This procedure is similar to one used by Chase and Holmes (1990), except that they used the lowest of the two ratings when there was no agreement, rather than reaching a consensus rating.

Client Satisfaction Questionnaire (CSQ-8)

To evaluate clients' satisfaction with the family therapy service the CSQ-8 (Nguyen, Attkisson and Stegner, 1983) was sent by post. A copy of the questionnaire and accompanying letter can be found in the appendices. 22 clients met the criteria of a year long follow-up period after therapy. Clients were

informed in the accompanying letter that their responses would be anonymous and would not be shown to staff in the family therapy team.

Results

Referrals to the clinic

A total of 71 clients were referred to the family therapy clinic between September 2000 and September 2004. Of these referrals, 29 (41%) completed a minimum of two sessions of therapy, allowing for a one year follow-up period at the time of data collection. The outcome for all 71 referrals is presented in table 1 in the appendix. The largest group was those that completed therapy (41%). clients who had attended for less than two sessions or not engaged with the service were a similar size to the therapy group (38%). The miscellaneous group accounted for 21% of referrals. The average wait time for the first appointment for all referrals was 162 days, with a range from 0 to 573 days.

Referral source

Details about the referral source are shown in table 2 in the appendix. Most referrals to the family therapy clinic came from clinical psychologists, with consultant psychiatrists second and community psychiatric nurses (CPNs) third. However, although clinical psychologists made the most referrals, more than half of these referrals did not eventually receive therapy. In contrast, half of the referrals from consultant psychiatrists received therapy.

Demographic information of the referrals

The average age for identified clients was 40 years old with a range from 17 to 82. There were 23 men (32%) and 48 women (68%) referred to the clinic. Therefore, 36% more women than men were referred during the audit period. The age and wait time results according to gender for the three main groups are

summarised in table 3 in the appendix. Generally the age ranges were similar in each of the three main outcome groups.

A statistical test was carried out to compare whether the clients in the therapy, non-engaged and miscellaneous groups had any differences in their age and wait time. Given the small sample sizes and the skewed distributions within the age and wait time data, a non-parametric measure (i.e. Kruskal-Wallis) was chosen. The two null hypotheses tested were that there is no difference in the ages between the three groups and no difference in the wait time between the three groups. The results for the age data gave a chi-square of 0.498, $df = 2$, $p = 0.783$. Therefore the null hypothesis for the age data was accepted at the 5% level of significance ($p=0.783 > 0.05$). The results for the wait time data gave a chi square of 2.43, $df = 2$, $p = 0.297$. Therefore the null hypothesis was accepted for the wait time data at the 5% level of significance ($p=0.297 > 0.05$). These results indicate that there was no difference between the three groups in terms of age and wait time for the first appointment.

Diagnosis of referrals

Table 4 in the appendix shows the main diagnosis of identified clients referred to the family therapy clinic. Clients in the therapy group had a wide range of diagnoses, as shown in figure 1 below. There were 10 clients in the non-engaged group who were diagnosed with depression. This figure was composed of 9 clients who declined the offer of therapy and 1 who was assessed as inappropriate for therapy.

Analysis of therapy group data

Time spent in therapy

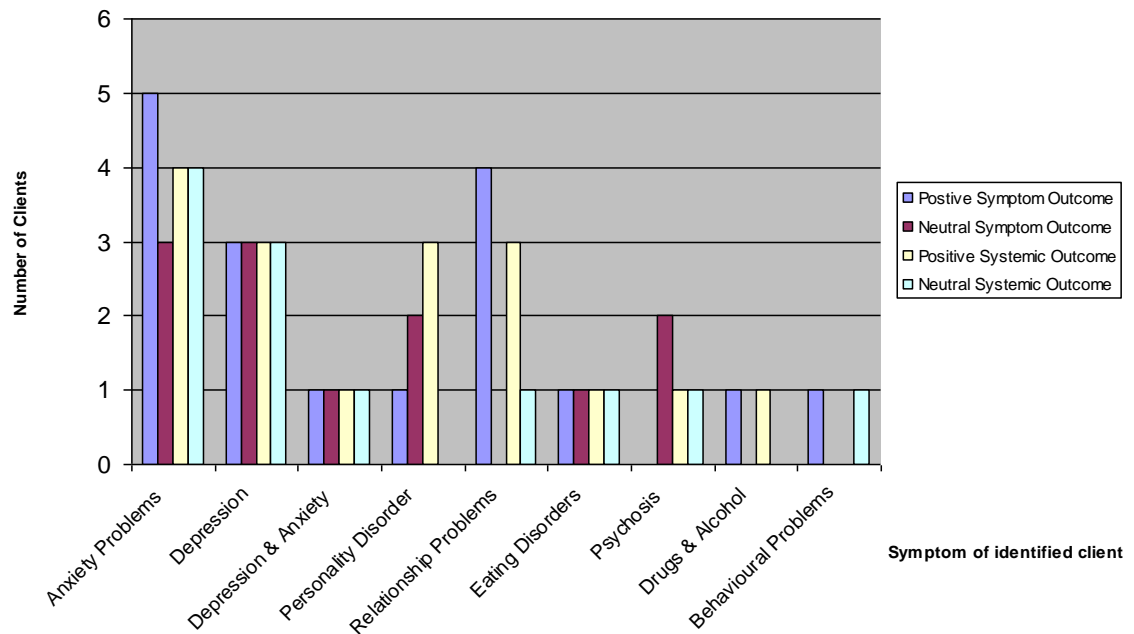
The average amount of time that a family spent in therapy was 325 days (range from 14 to 915 days, standard deviation of 264 days). The average number of

therapy sessions was 14 (range from 2 to 50 sessions, standard deviation of 11.3 sessions).

Outcome data

The results for the outcome according to the symptom of the identified client are shown in figure 1 below:

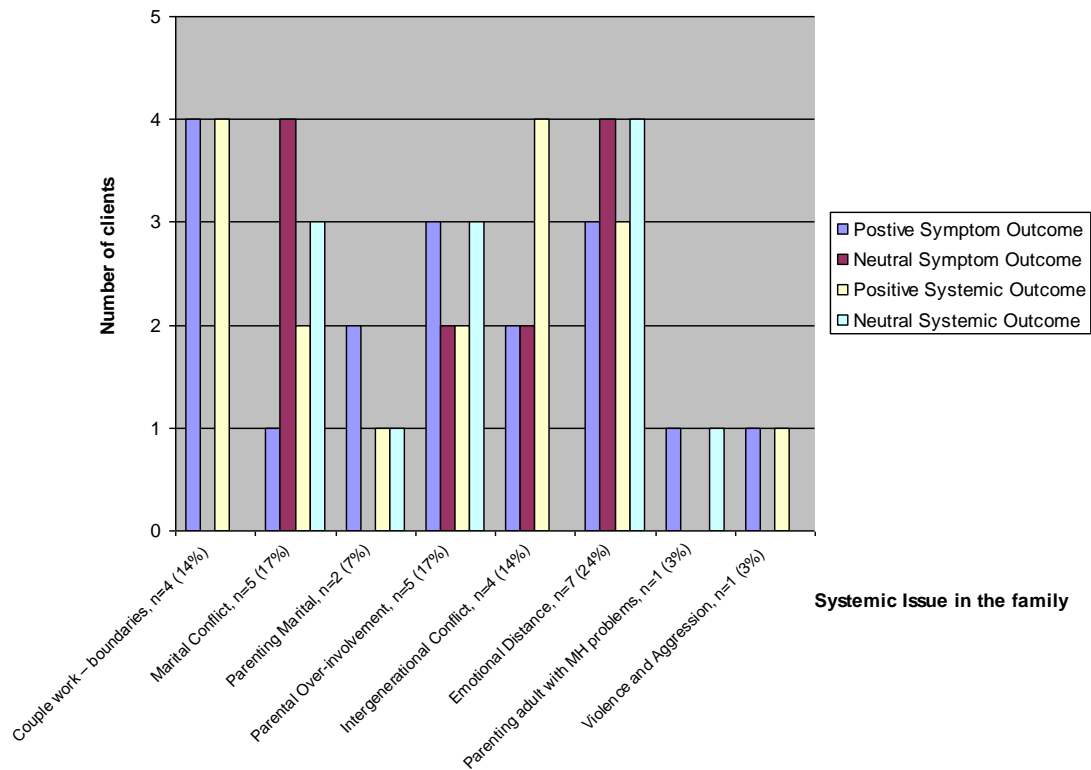
Figure 1: Graph to show symptom and systemic outcome for 29 clients who received therapy at a family therapy clinic between September 2000 and September 2004. The data is grouped according to the symptom of the identified client.



The graph shows that there were positive symptom and systemic outcomes for a range of presenting diagnoses, but generally the results were balanced between positive and neutral change for each diagnostic group. Although there were no positive symptom outcomes for people with psychosis, there were positive systemic outcomes for this group. Also notable is that there were mixed positive and neutral results for the symptoms of the personality disorder group, but all

these families had a positive systemic change following therapy. The data was also grouped according to the main presenting systemic issue in the family. The results for the outcome grouped by the main presenting systemic issue are shown in figure 2 below:

Figure 2: Graph to show symptom and systemic outcome for 29 clients who received therapy at a family therapy clinic between September 2000 and September 2004. The data are grouped according to the main presenting systemic issue in the family.



The most common presenting systemic issue was emotional distance. In total, 17 clients (59%) had a positive symptom outcome and 17 clients (59%) had a positive systemic outcome following therapy. As a percentage of the total number of referrals to the clinic, this represents a 24% positive symptom outcome rate and a 24% positive systemic outcome rate. It was not always the case that a positive systemic outcome would also indicate a positive symptom outcome. Additional statistical analysis was conducted on the outcome data to examine the

effects of the wait time, number of therapy sessions and time spent in therapy on the therapy outcome. These results are summarised in table 6 below:

Table 6: Results of Mann Whitney U tests to determine whether the variables of wait time, therapy sessions and length of therapy affected the symptom and systemic outcome for 29 clients attending a family therapy clinic

	Variable	Mann-Whitney U	Z	P (2 tailed)
Symptom outcome	Wait time	92.0	-0.443	0.658
	No. therapy sessions	54.5	-2.12	0.035
	Length of therapy	54.0	-2.13	0.033
Systemic outcome	Wait time	90.0	-0.532	0.595
	No. therapy sessions	76.5	-1.13	0.258
	Length of therapy	81.5	-0.909	0.364

For the symptom outcome results, the null hypothesis tested was that there was no difference in the positive and neutral outcome for the wait time, number of therapy sessions and length of therapy. The null hypothesis was accepted for the wait time data at the 5% level of significance ($p=0.658 > 0.05$). However, the null hypothesis was rejected for the number of therapy sessions at the 5% level of significance ($p=0.035 < 0.05$) and length of therapy ($p=0.033 < 0.05$). Inspection of the data reveals that clients who had more therapy sessions and spent more time in therapy were more likely to have an improvement in symptoms.

For the systemic outcome results, the null hypothesis tested was that there was no difference in positive and neutral outcome for the wait time, number of therapy sessions and length of therapy. The null hypothesis was accepted for the wait time ($p=0.595 > 0.05$), number of therapy sessions ($p=0.258 > 0.05$) and

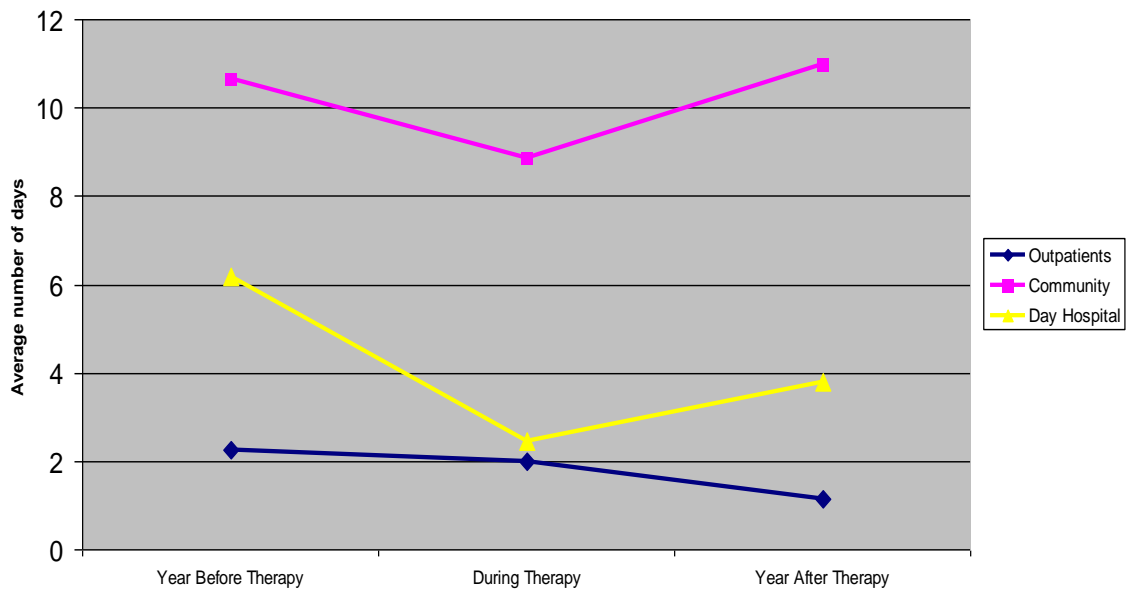
length of therapy ($p=0.364 > 0.05$). This indicated that there was no significant effect of wait time, therapy sessions or length of therapy on the systemic outcome.

Did therapy affect the use of other mental health services?

Clients' use of mental health services in the year prior to therapy, during therapy (prorated) and the year after therapy is presented graphically in figure 2 below.

The graph shows that use of community services did not seem to change much over time, perhaps slightly decreasing whilst the clients were in therapy, but then returning to previous levels following therapy. However, there does appear to be some indication that use of outpatients services and day hospital services decreased following therapy.

Figure 2: Graph to show use of mental health services before, during and after therapy for 29 clients who received therapy from a family therapy clinic between September 2000 and September 2004



Client satisfaction survey

Owing to the time of administration of the questionnaire, 22 clients had completed the minimum year long follow-up period after receiving therapy in order to qualify for the client satisfaction survey. The response rate was low, with only four completed questionnaires returned (18%). This prevented detailed analysis of the questionnaire data, a summary is presented in table 7 in the appendix.

Discussion

Summary of Results

The family therapy clinic received 71 referrals between September 2000 and September 2004. The total number of clients completing a minimum of two sessions of therapy was 29 (41%). Most referrals came from clinical psychologists. The average wait time for the first appointment was 162 days, with a range of 0 to 573 days. There was no significant difference in wait time or age between clients who received therapy and those that did not receive therapy or engage in therapy. Clients with a diagnosis of depression were the most common referral and the largest client group seen in therapy.

For clients receiving therapy, the average amount of time spent in therapy was 325 days, with an average of 14 therapy sessions. Generally there were positive symptom outcomes across a range of identified client diagnoses. Emotional distance was the most frequent presenting systemic issue in the family. The rate of positive systemic outcome for clients receiving therapy was 59% and the rate of positive symptom outcome was also 59%. The length of wait time before therapy was not related to the symptom or systemic outcome. Clients who received more therapy sessions and spent longer in therapy were more likely to have a positive symptom outcome. The systemic outcome was not affected by the number of therapy sessions or length of time spent in therapy.

Finally, there was some limited evidence to suggest that use of outpatients services and day hospital services had decreased following therapy.

Relationship to previous findings

The results of this audit compare favourably with the previous unpublished audit completed in the year 2000. The successful outcome after therapy was coincidentally exactly the same for the two studies, with a positive change rate of 24% of the total referrals to the service. However, there is a difference in the calculation of this figure between the two studies. In the 2000 study it represented an amalgamation of first and second order change. However, although the rate is 24% in this study, it is 24% for first order change and 24% for second order change. The same clients are not represented in the first order and second order change.

The number of referrals had almost doubled (37 in the year 2000, 71 in this study), perhaps reflecting greater awareness of the service. Notably, the positive change rate had remained the same with an increase in referrals. The non-engaged rate was also lower in this study (54% in 2000, 38% this study). There may be a number of possible reasons for this improvement including receiving referrals from families that are more likely to engage with the team and also the greater experience of the therapists reflecting better engagement skills. The 59% successful first and second order outcome rates for clients who received therapy compare favourably with previous findings of Bloch, Sharpe and Allman (1991) who had a change rate of 68% for first order change and 52% for second order change. Chase and Holmes (1990) in their sample of 34 families seen for therapy found 22 families attended for up to 10 sessions and 12 families attended for between 11 and 15 sessions. The average number of 14 sessions found in this study would seem to fit with these previous findings. These authors also found that in psychotic clients second order change occurred in the absence

of first order change, which was echoed in the findings from this study. It is possible that the randomised controlled trials used in the Cochrane Review (Pharoah et al. 2003) tend to focus on first order change. This study adds weight to comments by Lerner (2004) that the full picture of family therapy processes may not be obtained from the methodological constraints of randomised control trials.

Implications of the findings from this study

The results of this study seem to indicate that the family therapy clinic has made improvements in terms of outcome for referrals to the service since the previous audit in the year 2000. It also appears that the rate of engaged families has improved. It is possible that this reflects the greater experience and engagement skills of the therapists. It may also be possible that more appropriate referrals are being received. For example, referral skills of other mental health professionals may have improved. Greater liaison between the therapists and other professionals may also ensure that referrals are more likely to be suitable before they are made to the clinic. It appears that consultant psychiatrists were more likely to make referrals that would eventually engage in therapy. Clinical psychologists and CPNs were most likely to make referrals that did not engage in therapy. It may helpful to provide information or have discussions about making referrals with these two professional groups in order to improve the number of referrals they make that engage in therapy.

Areas for further investigation

Although the wait time did not have an impact on likelihood to engage in therapy, there did appear to be some large wait times in the current sample. Individual circumstances that may have prolonged the wait time were not always available for this audit and further study of factors that affected the wait time may be helpful in order to reduce wait times for the future. Investigation of reasons why more

than half of the referrals with a diagnosis of depression did not engage in therapy would also be helpful. Finding the factors that may influence engagement of this client group may be helpful to increase their attendance at the clinic. Future studies could also investigate whether attendance at the clinic affects the level of care required in the community care plans of identified clients.

Improvements to this study

Unfortunately the low return rate of the client satisfaction survey limited useful information being obtained from this part of the study. One problem with the timing of this survey was that for some clients there had been a delay of a few years between their therapy ending and receiving the questionnaire. This may have meant that factors influencing low response rates were more likely to take place, such as the survey having little relevance to the participants or participants being unable to remember their experiences and therefore not completing the survey. Therefore it will be recommended to the team that client satisfaction questionnaires are sent to clients soon after their course of therapy has ended to increase the return rate of questionnaires. A further improvement related to client satisfaction would be to examine the relationship between clients' satisfaction and their therapeutic outcome. This would require a more detailed study, including non-anonymous questionnaire returns, that was beyond the time limits of the present study. The satisfaction survey could also be improved by extending it to all family members who presented to the clinic to obtain their view too; the present survey only included the identified client.

Other areas of improvement include collecting further information on clients who did not engage in therapy, such as their use of services. This would help us to understand the needs of this client group, for example they may have used other services rather than family therapy. Comparing these clients to the clients who did engage in therapy may enable development of engagement practices with these clients.

The outcome data to this study could have been improved by using a standardised measure for family therapy research, such as the Beavers Interactional Scales (Beavers and Hampson, 1990). As noted by Beavers and Hampson (2000), these scales have proved useful in research and clinical work to evaluate family members' perception of their competence on a range of areas including communication, managing conflict and styles of interaction. If this measure was completed prior to therapy and then at the end of therapy, it may provide additional information about the way that therapy can lead to improvements in systemic outcome. Use of this measure will be recommended to the family therapy team.

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Appendices

Appendix 1: Tables and figures not included in main text

Appendix 2: Letter sent to clients who received therapy asking them to complete the client satisfaction questionnaire

Appendix 3: Client Satisfaction Questionnaire posted to all clients who received therapy

Appendix 1: Tables and Figures not included in main text

Table 1: Table to show the final outcome for 71 referrals to a family therapy clinic, divided into three groups. The referrals were made between September 2000 and September 2004.

Final outcome according to group	N	Percentage of referrals (%) (2 s.f.)
<i>Therapy Group:</i>		
Assessed as appropriate and completed therapy	29	41
Total	29	41
<i>Non – Engaged or Unsuitable:</i>		
Assessed as inappropriate	2	3
Non-engaged (no contact after appointment offered)	10	14
Declined therapy	15	21
Total	27	38
<i>Miscellaneous:</i>		
Removed from wait list	2	3
Began therapy and still in therapy	2	3
Deceased	1	1
Assessed as appropriate and on the waiting list	3	4
On waiting list but moved out of the area	3	4
Screened out as inappropriate before assessment	4	6
Total	15	21
Grand Total	71	100

Table 2: Profession of referrer for 71 referrals to a family therapy clinic between September 2000 and September 2004.

Profession	N and Percentage (%) (2 s.f.)	Group		
		Therapy	Non- Engaged	Miscellaneous
Consultant Psychiatrist	14 (20%)	7	3	4
Clinical Psychologist	25 (35%)	9	12	4
Community Psychiatric Nurse	19 (27%)	8	8	3
Social Worker	5 (7%)	3	2	0
Occupational Therapist	1 (1%)	1	0	0
General Practitioner	1 (1%)	1	0	0
Staff Nurse	4 (6%)	0	2	2
Assistant Psychologist	1 (1%)	0	0	1
Nutritionist	1 (1%)	0	0	1
Total	71 (100%)	29	27	15

Table 3: Gender, age and wait time for 71 referrals to a family therapy clinic according to group outcome

Group	Gender	N (%)	Age		Wait Time	
			Mean	Range	Mean	Range
Therapy	M	11 (15)	37	18 – 57	137	20 – 406
	F	18 (25)	39	19 – 75	144	14 – 573
Non-Engaged	M	6 (8.5)	50	30 – 81	150	28 – 273
	F	21 (30)	39	17 – 82	162	0 – 413
Miscellaneous	M	6 (8.5)	32	19 – 60	253 *	112 – 387 *
	F	9 (13)	45	21 – 63	233 †	34 – 567 †

Nb. * = 2 referrals not included in figure because no wait time data available

† = 5 referrals not included in figure because no wait time data available

Table 4: Main diagnosis of 71 clients referred to a family therapy clinic. The table also shows the referrals by group.

Diagnosis	N (%)	Group		
		Therapy	Non-Engaged	Miscellaneous
Anxiety	9 (13)	4	5	0
Depression	18 (25)	6	10	2
Depression and Anxiety	2 (3)	2	0	0
Panic Attacks	2 (3)	2	0	0
Obsessive Compulsive Disorder	4 (6)	2	0	2
Personality Disorder	9 (13)	3	1	5
Relationship Problems	6 (8)	4	1	1
Eating Disorder	6 (8)	2	3	1
Psychosis	2 (3)	2	0	0
Drugs and Alcohol	1 (1)	1	0	0
Behavioural Problems	2 (3)	1	1	0
Childhood Sexual Abuse	3 (4)	0	3	0
Other	7 (10)	0	3	4
Total	71	29	27	15

Table 7: Questionnaire results for 22 clients who received therapy from a family therapy clinic.

Client	Total score (min 0, max 24)	Additional comments
1	7 (29 th %ile)	'Unhappy with location' 'Therapy recommended wasn't right for me' 'Being videoed leaves me with bad feelings' 'A time in my life I'd rather forget'
2	15 (63 rd %ile)	No comments added
3	16 (67 th %ile)	'It's likely that family therapy produced some positive results we weren't aware of at the time'
4	21 (88 th %ile)	'Service was very helpful and proved it's worth which two years later shows in the family relationships'

NB. A score of 0 would indicate rating all answers as 'poor' or 'low satisfaction'. A score of 24 would indicate rating all answers as 'excellent' or 'very satisfied'.

Appendix 2: Letter sent to clients who received therapy asking them to complete the client satisfaction questionnaire

Department of Clinical &
Neuropsychology

Mr X
Address Line 1
Address Line 2
Post code

Address Line 1
Address Line 2
Address Line 3
Post code

Tel: xxxxxxxx
Fax: xxxxxxxx

Date

Dear Mr X,

Subject: Family Therapy Service Evaluation

My name is xxxxxx and I am a trainee clinical psychologist working at xxxx Hospital. I am writing to you because in (*insert date and time period*) you attended the family therapy clinic run by (therapist 1) and (therapist 2) for (*insert no. of sessions*). I am currently conducting a study to see if attending the clinic was helpful and to see if there are any ways in which it could be improved.

An important part of this project is to find out the views of people who attended the clinic. I have therefore enclosed a questionnaire which asks some questions concerning your time there. I would be very grateful if you could complete the enclosed questionnaire and return it in the envelope provided. You do not have to pay for postage because a stamp is already on the envelope.

You may choose freely whether to take part in this study. Your questionnaire will not be shown to the therapists at the clinic and your answers will be kept anonymous. Please answer the questions as honestly as possible because it will help us to improve the clinic for people who use it in the future. Please be assured that your decision to take part will not affect your current or future care.

If you have any questions about the project and would like to talk about it in more detail, please do not hesitate to contact me on xxxxxxxx.

Yours sincerely,

Tim Sporle
Trainee Clinical Psychologist

Appendix 3: Client Satisfaction Questionnaire posted to all clients who received therapy

Client Satisfaction Questionnaire

Please help us to improve our service by answering some questions about the service you have received.

We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions.

Thank you very much, we appreciate your help.

CIRCLE YOUR ANSWER

1. How would you rate the quality of the service you have received?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did you get the kind of service you wanted?

1	2	3	4
No, definitely not	No, not really	Yes, generally	Yes

3. To what extent has the service met your needs?

4	3	2	1
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend were in need of similar help, would you recommend our service to him or her?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. How satisfied are you with the amount of help you have received?

1	2	3	4
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

6. Have the services you received helped you to deal more effectively with your problems?

4	3	2	1
Yes, they helped a great deal	Yes, they helped somewhat	No, they really didn't help	No, they seemed to make things worse

7. In an overall, general sense, how satisfied are you with the service you have received?

4	3	2	1
Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

8. If you were to seek help again, would you come back to our service?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

9. Do you have any further comments or suggestions?

Literature Review:
A review of traumatic life events as a cause of psychosis

Introduction

This review provides a summary of the literature concerning how traumatic life events may cause psychosis. As noted by Morrison, Frame and Larkin (2003), there are three main hypothetical relationships between traumatic life events and psychosis:

1. Traumatic life events cause psychosis
2. Psychosis is a traumatic life event that causes Posttraumatic Stress Disorder (PTSD)
3. Psychosis and PTSD could both be part of a spectrum of responses to a traumatic event

Given the wealth of literature examining these three relationships this review will be limited to evidence examining traumatic life events as a cause of psychosis. For further discussion of psychosis as a traumatic experience that may lead to PTSD see Shaner and Eth (1989), McGorry et al. (1991), Lundy (1992), Frame and Morrison (2001) and Steel (2006). It is also felt by these authors that there is considerable overlap of symptoms of psychosis and PTSD. This will not be discussed in this review due to space constraints. However, Hamner et al. (2000) note that psychotic features may often be undetected in PTSD due to this overlap. Finally, there is a growing literature on hospitalisation as a traumatic event for people who have psychosis (e.g. Jackson, Knott, Skeate and Birchwood, 2004 and Shaw, McFarlane, Bookless and Air, 2002) which will not be reviewed.

The relationship between trauma and psychosis is worth studying from a psychological perspective. For example, Read, Agar, Argyle and Aderhold (2003) note that thorough consideration of the relationship between trauma and psychosis is essential for the development of accurate formulations and

comprehensive treatment plans for people who have psychosis. This review will begin with definitions of trauma and psychosis. The main findings from 14 recent literature reviews will be summarised. Prospective studies and studies using the general population will then be reviewed. After discussion of the link between childhood abuse and psychosis, the evidence for trauma as a cause of specific symptoms of psychosis will be reviewed. Models of PTSD will not be reviewed, but will be considered in relationship to the development of psychological models of trauma and psychosis. This review will conclude with suggestions for future research, including consideration of the construction of self in psychosis and its relationship to traumatic life events.

Definitions of Trauma and Psychosis

The Oxford English Dictionary (OED) defines trauma in relation to psychiatry as 'A psychic injury, especially one caused by emotional shock, the memory of which is repressed and remains unhealed' (OED, 1989). For this review, a more accurate definition includes 'The experience of an uncontrollable event which is perceived to threaten a person's sense of integrity or survival' (APA, 1994). As noted by Read and Ross (2003) potentially traumatic events could include physical and sexual abuse, neglect, family violence and chaos, military combat, death of primary caretakers, war and imprisonment. This review will focus on research suggesting trauma is a cause of psychosis. The OED defines psychosis as:

'Any mental illness or disorder that is accompanied by hallucinations, delusions or mental confusion and a loss of contact with external reality, whether attributable to an organic lesion or not' (OED, 1989)

In recent years researchers have established that there is a high frequency of exposure to trauma in patients who have psychosis. Mueser et al. (1998) found in their sample of 275 people with severe mental illness that 98% reported experiencing at least one traumatic life event. Similar findings in a first episode psychosis group were found by Neria, Bromet, Sievers, Lavelle and Fochtmann (2002) where 68.5% of their sample of 426 patients had previous exposure to trauma. Also more recently, Kilcommons and Morrison (2005) found in a sample of 32 people with psychotic diagnoses that 94% had experienced at least one traumatic event prior to developing psychosis.

Search strategy

The aim of the search strategy was to identify recent literature reviews on the relationship between trauma and psychosis. They would provide a summary of evidence and a starting point for obtaining literature. The diagnosis of schizophrenia includes symptoms of psychosis (APA, 1994). However, people who have experienced psychosis may have any number of diagnoses including schizophrenia, bi-polar disorder and schizoaffective disorder (e.g. Read, van Os, Morrison and Ross, 2005). Therefore the term 'psychosis' was used in search strategies to capture all diagnoses with psychotic features. The term 'schizophrenia' was also used because of its association with psychotic symptoms. The search strategies using these two terms are outlined in Appendix 1. The papers identified by these searches are shown in Appendix 2. Two additional review papers obtained by author searches were added to the collection making a total of 14 review articles which are summarised in the next section.

Summary of Recent Review Findings

General Findings

The review papers identified generally supported the view that traumatic experiences could be a cause of psychosis (e.g. Read 1997, [Goodman, Rosenberg, Mueser and Drake](#), 1997, Read and Ross, 2003, Morrison et al. 2003) and associated with increased suicide risk in people with a diagnosis of schizophrenia (Range et al., 1997). Goodman, Rosenberg, Mueser and Drake (1997) found that women with schizophrenia and other major mental illnesses had an extremely high incidence and prevalence of violent victimization. They noted that causal links were not well understood, but that victimisation of women with schizophrenia was related to symptom levels, risky behaviour and such comorbid conditions as homelessness and substance abuse. Read (1997), Read, et al. (2003) and Read et al. (2005) all found that childhood sexual abuse (CSA) and childhood physical abuse (CPA) are strongly related to symptoms of psychosis. General findings on the relationship between trauma and psychosis were reflected in comments by Read and Ross (2003). They stated that regardless of causal, contributory, co-morbid or co-incidental views, the fact remained that there was a high prevalence of trauma in schizophrenia. They felt this warranted full trauma assessment of all people who experience psychosis and appropriate psychological treatments to address the impact of trauma or abuse on their symptoms.

Biological and Environmental factors

The source of trauma is found within an individual's environment. Two papers reviewed environmental factors to examine how they might be linked to the risk for developing schizophrenia ([Myin-Germeys, Krabbendam and van-Os](#), 2003, and [van-Os, Krabbendam, Myin-Germeys, and Delespaul](#), 2005). These authors

felt that environmental factors interact with genetic factors in a neurodevelopmental model. The main environmental risk factors for developing schizophrenia were identified as cannabis use, living in an urban area, being from an ethnic minority, early trauma and prenatal and early childhood stresses. van Os et al. (2005) felt that early exposure to trauma may increase the risk of dysfunctional responses to early psychotic experiences. Therefore, when psychotic-like experiences occurred in later life they were more likely to lead to the formation of psychotic symptoms. They felt that stresses such as drug use and social adversity might propel the neurodevelopmentally impaired individual over a threshold that would lead to psychosis. [Bunney, Bunney, Stein and Potkin \(2003\)](#) also hypothesised a neurodevelopmental model of trauma and psychosis but placed emphasis on the dorsolateral prefrontal cortex area of the brain as most likely to be implicated in the development of schizophrenia. [Kinzie and Friedman \(2004\)](#) felt that as the understanding of the neurobiology of trauma was increasing, more effective drug treatments for trauma and psychosis were being developed.

Measurement issues

Morrison et al. (2003) noted that many papers to date had problems with their samples and that the life events literature was still somewhat equivocal in relation to psychosis. Similar calls for further research came from [Deering, Glover, Ready, Eddleman, Alarcon \(1996\)](#) who felt that PTSD and its related psychiatric symptoms evolved through a cascade process in which a series of accumulated traumatic events, neurobiological changes and psychosocial stressors combined to form a complex set of PTSD and other psychiatric symptoms. They felt that single snapshot cross-sectional studies could not accurately measure this process. [Seedat, Stein, Oosthuizen, Emsley, and Stein \(2003\)](#) noted the controversy that still remained over the accuracy and reliability of reports of trauma in patients whose disorders are characterised by distortions of thought

and perception. Despite this confounding factor, they felt that the balance of evidence still suggested that trauma was associated with high levels of psychosis and general psychopathology. They felt the effects of exposure to trauma on neural networks may provide a common diathesis for disorders like PTSD and schizophrenia. Measurement issues were also raised by Bebbington, Bowen and Ramana (1997). Although they predominantly focused on the impact of events in relapse rather than as a cause of psychosis, the temporal accuracy of recall of stressful life events is an issue in both causal and relapse research. They noted that people who have psychosis may be unable to accurately recall when events occurred. However, they had made attempts to reduce some of these confounding factors in their cross-sectional research and found trauma still had an effect on relapse in psychosis. They also felt that stressful life events may precipitate first episodes of psychosis and felt more research was required in patients whose first onset appeared to have no psychosocial events prior to onset. They also noted that more research was required to examine the possibility that positive life events could play a causal role in psychosis. In summary, there appears to be general agreement from recent literature reviews that traumatic life events can cause psychosis. Some additional sources of evidence will now be reviewed.

Additional Sources of Evidence

Childhood Abuse Studies

The issue of childhood abuse warrants special attention because this often features in the trauma and psychosis literature. A number of reviews (e.g. Read, 1997, Read et al., 2003) have specifically investigated the link between childhood abuse and later psychosis. Ross, Anderson and Clark (1994) found in their sample of 83 inpatients with a diagnosis of schizophrenia that 37 reported a history of CSA or CPA. They also found that patients reporting CSA or CPA had

higher levels of dissociative symptoms and positive symptoms of psychosis. Ellason and Ross (1997) had a sample of 144 inpatients with a range of diagnoses including depression, bipolar disorder, dissociative disorder and dissociative identity disorder. They found that psychotic type symptoms were also linked to childhood trauma. They took this as an indication that trauma-driven psychotic symptoms could occur in a range of diagnoses. Read et al. (2003) found in their sample of 200 community patients that 92 had previous experience of sexual or physical abuse at some point in their lives. They found that child abuse was a significant predictor of auditory and tactile hallucinations, even in the absence of adult abuse. Lysaker, Meyer, Evans, Clements and Marks (2001) agreed with the findings that CSA could lead to psychosis and added that the experience of CSA in schizophrenia also resulted in poorer psychosocial functioning for patients. They felt this might be caused by CSA limiting patients' ability to form attachments and to function in socially defined roles.

Having briefly reviewed child abuse studies, it is important to note that adult abuse has been studied too. For example, Read et al. (2003) found that adult sexual assault was related to hallucinations, delusions and thought disorder. It should also be noted that traumatic events other than abuse in childhood have also been hypothesised to lead to psychosis. For example, Whitfield, Dube, Felitti and Anda (2005) have found that adverse childhood experiences, not limited to abuse, can increase the likelihood of hallucinations in later life.

Studies in the General Population

Findings from non-clinical populations also provide evidence that traumatic life experiences may cause psychotic symptoms. For example, Romme and Escher (1989) found evidence that hearing voices is linked to traumatic experiences. They found that 70% of their sample of people who heard voices but were not known to services believed that their voices had commenced following a

traumatic event. Traumatic events included accidents, divorce, death and illness. Berenbaum (1999) examined a sample of 458 college students. He found that those reporting a history of childhood maltreatment were 10.5 times more likely than those who did not have this history to have high perceptual aberration scores. Examples of items reflecting these high scores included 'feeling a part of your body didn't belong to you', or 'wondering if your body is really your own'. Ross and Joshi (1992) took a sample of 502 adults in the general population and examined the incidence of psychotic symptoms using the Dissociative Disorders Interview Schedule. They found that psychotic symptoms were highly correlated with childhood trauma.

Generally the studies reported above have found a relationship between traumatic life events as a cause of psychosis. However their cross-sectional designs don't give direct causal data (e.g. Hammersley, Dias, Todd, Bowen-Jones, Reilly and Bentall, 2003). Therefore to reduce some of these measurement problems prospective studies will be reviewed in the next section.

Prospective Studies

The advantages of prospective studies are that they reduce a number of potentially confounding factors that arise from experimental designs including small sample sizes, using self-report measures and requiring participants to remember previous episodes of abuse (e.g. Kilcommons and Morrison, 2005). Three studies were identified through PsychInfo (see appendix 3) and one through author searching. Spataro, Mullen, Burgess, Wells and Moss (2004) used a prospective cohort design and examined the mental health treatment of a sample of 1612 children who had suffered penetrative abuse. They found that both male and female victims of abuse had significantly higher rates of psychiatric treatment. The increases were significant for major affective disorders, anxiety disorders, personality disorders and disorders of childhood.

They noted that their results did not find a difference between cases and controls for schizophrenia. However, they emphasised caution with this finding because subjects at follow-up may not have reached the peak years for developing schizophrenia and related disorders. The authors advised that CSA often emerges from a number of adverse life circumstances and that family, social, psychological and biological variables could play a role in the link between CSA and later use of mental health services.

Bebbington et al. (2004) examined data from 8580 adults who took part in the British National Survey of Psychiatric Morbidity (Singleton, Bumpstead, O'Brien, Lee and Meltzer, 2001). The study compared respondents who had a definite or probable psychosis with those who had neurotic disorders, alcohol dependence or drug dependence. The results indicated the psychosis group had an elevated prevalence of a number of experiences, including sexual abuse, bullying, being taken into care, violence in the home and being homeless. They concluded that psychosis may emerge especially in people who have been subjected to victimising events and that therapy should continue to focus on the meaning of traumas in relation to psychotic experiences. An 18 month follow-up study of the subjects in Bebbington et al. (2004) was conducted by Wiles et al. (2006). Incident cases – people who had not endorsed psychosis items at baseline but who did at follow-up – were identified. Factors at baseline in incident cases were examined. Factors independently associated with incident psychotic symptoms included having a small primary support group, adverse life events, neurotic symptoms and engaging in a harmful drinking pattern.

Janssen et al. (2004), used data from a population survey in the Netherlands, The Netherlands Mental Health Survey. The sample was 4045 subjects aged 18-64. Childhood abuse, measured at baseline, was reported by 10.5% of the sample. The subjects were then followed up 2 years later and assessed for first ever onset of psychotic symptoms. The results indicated that baseline childhood abuse predicted development of positive psychotic symptoms

in later life. A population study by Spauwen, Krabbendam, Lieb, Wittchen and van Os (2006) used data from the Early Developmental Stages of Psychopathology study in Germany. At baseline, 2524 adolescents aged 14-24 provided self-reports on psychological trauma and psychosis proneness (experience of any psychotic-like symptoms at baseline). Participants were then interviewed, on average 42 months later, for presence of psychotic symptoms. The results found a clear and specific relationship between psychological trauma and psychosis. The association between trauma and psychosis increased in a dose-response fashion with the number of traumatic events. They also found that adolescents with a pre-existing vulnerability to psychosis had much stronger associations with trauma and psychosis than in those without such vulnerability. In summary, the findings from prospective studies support the view that traumatic life events can cause psychosis. The next section will turn to research examining the relationship between specific symptoms of psychosis and traumatic life events.

Traumatic Life Events and Specific Symptoms of Psychosis

Hallucinations

Research suggests that there is a strong relationship between hearing voices and experience of traumatic life events. Ross, Anderson and Clark (1994) found in their sample of 83 patients with schizophrenia that 68.6% of abused patients heard voices commenting versus 26% of non-abused patients. Therefore, in their sample, patients who had experienced trauma were more likely to hear voices commenting on their behaviour. Hammersley et al. (2003) in their sample of 96 patients with bipolar affective disorder found a significant association between those reporting trauma and auditory hallucinations and a highly significant relationship between CSA and auditory hallucinations. Honig, Romme, Ensink, Escher, Pennings and Devries (1998) examined auditory hallucinations in three

groups, patients with a diagnosis of schizophrenia (n=18), patients with a dissociative disorder (n=19) and non-patient voice-hearers (n=15). For most participants across all three groups, the onset of auditory hallucinations was preceded by either a traumatic event or an event that activated the memory of an earlier trauma.

Research also suggests that the content of the voices may be related to earlier traumatic experiences. Read and Argyle (1999) examined 100 consecutive admissions to an inpatient unit in New Zealand. 22 patients had a history of CPA or CSA and of these, 11 experienced auditory hallucinations. CSA was particularly related to the content of the voices in half of this sample. For example, hearing the voice of the person who abused you or hearing commands related to the way that you had been abused. Given this link, the authors felt that hypotheses that hallucinations of abuse survivors are 'pseudohallucinations' was not supported. Read et al. (2003) found examples where voices were linked to earlier experiences of abuse. For example, one client who was sexually abused had auditory hallucinations in the form of the abuser and another client who was abused heard the voice of the perpetrator telling them to 'touch children'.

Other research has looked at hallucinations in general rather than specifically focusing on hearing voices. For example, Hardy et al. (2005) found in their sample of 75 patients with nonaffective psychosis that 40 had experienced trauma. 12.5% of this trauma subgroup had hallucinations with similar themes to their trauma and 45% had hallucinations in which the themes were the same but not the content. In their sample, the traumas most likely to be associated with hallucinations were sexual abuse and bullying. However, 42.5% of their trauma subgroup had no identifiable association between their hallucinations and previously experienced trauma. This point will be discussed further below.

To conclude this brief review of links between trauma and hallucinations, Whitfield et al. (2005) examined the relationship between the severity of the trauma and how this affected the likelihood of developing hallucinations. 17,337

members of a health care plan were asked questions about childhood abuse and household dysfunction. Compared to people with no adverse childhood experiences, people with seven or more adverse childhood experiences had a five-fold increase in the risk of reporting hallucinations. Whitfield et al. (2005) felt that these findings added to the literature that childhood trauma can lead to hallucinations in later life. However, they noted that future research needs to examine the mechanism by which this takes place.

Delusions

Generally, studies investigating the presence of hallucinations have also investigated delusions. For example, Read and Argyle (1999) and Read et al. (2003), have both investigated the links between traumatic experiences and delusions. Read et al. (2003) had 58 patients who experienced delusions in their sample of 200 outpatients. Delusions were not significantly related to CSA or CPA, or both in combination. However, patients experiencing abuse in adulthood were significantly more likely to experience delusions than non-abused patients. Read and Argyle (1999) had similar findings in that delusions were not as common as hallucinations among patients who had experienced CSA. However, there was some evidence that the content of the delusions was related to earlier traumatic experiences. For example, one patient who had been abused believed that 'men were out to get her and harm her or sexually molest her'.

Bleich and Moskowitz (2000) reported six cases of Israeli war veterans who developed PTSD after their war experiences and who sometime after their war trauma then began to suffer from psychosis. Delusions of persecution (e.g. persecutors trying to harm them as vengeance for war killings), paranoid delusions and auditory hallucinations were all common in their patients, which seemed to be directly linked to their earlier trauma. They felt that in certain conditions exposure to trauma and / or PTSD may serve as a trigger for psychosis and that PTSD and psychosis were two closely related phenomena.

Although the evidence suggests a strong relationship between traumatic life events and delusions, the results are not conclusive. For example, although Hammersley et al. (2003) found a relationship between trauma and hallucinations, they found no relationship between delusions and CSA in their sample of 96 people with bipolar affective disorder.

Thought Disorder

Read and Argyle (1999) found in their 22 patients with a previous history of abuse that six had thought disorder, however only one patient had any content of their thought disorder recorded so no further analysis was possible. Read et al. (2003) noted that the literature on CSA and thought disorder is small. In their sample they found that thought disorder was not related to CSA or APA. However, a combination of child and adult abuse was a significant predictor of thought disorder. Therefore at present further research on possible links between traumatic life events and thought disorder is still required before firm conclusions can be made.

Models of Traumatic Life Events and Psychosis

The evidence to date from literature reviews, cross-sectional studies and prospective studies generally indicates that there is a strong relationship between traumatic life events and psychosis. However, some research has found no relationship (Brown and Anderson, 1991) or only a moderate relationship e.g. Hardy et al. (2005). Brown and Anderson felt their results may have been due to their inability to gain accurate abuse histories from psychotic patients. Nonetheless it is possible that not all symptoms of psychosis have traumatic causes. It may be possible to enhance our understanding of circumstances when traumatic life events are a cause of psychosis and also when other factors are a

cause of psychosis by consideration of the models that will be briefly reviewed below.

Bio-psycho-social models of trauma and psychosis

In the 1970's, the diathesis-stress model of schizophrenia came to the fore, with the central notion that the behavioural expression of the biological vulnerability for schizophrenia was influenced by exposure to stress (Walker and Diforio, 1997). The diathesis-stress model has been incorporated into bio-psycho-social models of schizophrenia. For example, having noted the high prevalence of child abuse in adults diagnosed with schizophrenia, Read, Perry, Moskowitz and Connolly (2001) proposed a traumagenic neurodevelopmental model. In their model, childhood trauma would cause long-lasting neurodevelopmental changes. Rather than assuming a bio-genetic aetiology for schizophrenia, the model proposes that differences in the brains of people diagnosed schizophrenic would be caused by adverse life events. Although these models are favoured by other researchers (e.g. Whitfield et al., 2005) some researchers have placed more weight on the biological components of the bio-psycho-social model. For example, van Os et al. (2005) and Myin-Germeys et al. (2003) also acknowledge the role of environmental factors in the development of psychotic symptoms. However, they place greater emphasis on genetic predispositions to develop psychosis. It is then social and environmental stress that interacts with the genetic predisposition to cause psychosis.

Read (2005) has criticised bio-psycho-social models for focusing too heavily on the 'biological' aspects and not enough on the 'psychological' aspects when considering how trauma may cause psychosis. In general though, the bio-psycho-social model provides a useful framework for conceptualising how traumatic life events may cause psychosis. Further research on the relationship between trauma and psychosis will enhance our understanding of how biological, social and psychological factors interact in the development of psychosis. An

example of the use of this framework to generate hypotheses for the development of psychosis can be found in Ross, Anderson and Clark (1994). They propose there may be at least two possible pathways to symptoms of schizophrenia. The first would be primarily endogenously driven and accompanied by negative symptoms. The second would be primarily driven by childhood psychosocial trauma and accompanied by more positive symptoms.

Bio-psycho-social models may also help us to account for when psychosis does not appear to have been caused by obvious traumatic life events. They may lead us to consider other factors rather than traumatic life events. It is possible that a reason why evidence to date has not found strong links between thought disorder and traumatic life events is because thought disorder has more subtle causes than an immediately obvious traumatic cause. However, even if this has a more biological cause, bio-psycho-social models do allow us to consider how biological factors are shaped by psychological and social factors.

Cognitive models of trauma and psychosis

Following on from the bio-psycho-social framework, cognitive models examine more closely the psychological factors in psychosis. Garety, Kuipers, Fowler, Freeman and Bebbington (2001) proposed a cognitive model of positive symptoms of psychosis. They felt there was a vulnerable predisposition to develop psychosis that had a bio-psycho-social origin. Following these origins, life events and adverse environments could cause emotional changes and disruption in cognitive processes of attention, perception and judgement. The most prominent symptoms of these disruptions would be delusional beliefs and hallucinations. Other authors have integrated cognitive models of psychosis (e.g. Garety et al. 2001) with cognitive models of PTSD (e.g. Ehlers and Clark, 2000). For example, Morrison et al. (2003) felt that traumatic experiences contribute to the development of faulty self and social knowledge. Abuse may lead people to believe that they are vulnerable, others cannot be trusted and the world is

dangerous. Paranoia, suspiciousness and dissociation may become a way of coping with these beliefs and also with intrusive memories of traumatic experiences. If verbal post-traumatic intrusions occur, they may be elaborated and combined with dissociative phenomena to become experienced as voices. In summary, problematic, culturally unacceptable interpretations and the associated distress and disability would be maintained by cognitive, behavioural, emotional and physiological responses and the current environment. They felt that integrated approaches may be sufficient to explain the link between trauma and psychosis at least for some people. The integration of cognitive models of PTSD and psychosis has been found to be useful in therapy by Callcott, Standart and Turkington (2004) who used it to treat two patients with psychosis and a history of trauma.

Cognitive models allow exploration and development of our understanding of the links between trauma and psychosis. For example, Holmes and Steel (2004) have investigated how intrusive memories may play a role in the development of psychosis following traumatic life events. In their experiment, a non-clinical sample watched a trauma video, answered questionnaires and kept a diary of intrusive thoughts for one week. They also measured the sample by schizotypy – milder forms of schizophrenia in non-clinical populations. They found more reported trauma-related intrusions were associated with high schizotypy. High scoring schizotypes had a relatively weakened ability to integrate information within a temporal context which resulted in memories being stored in a manner that leaves them vulnerable to being triggered involuntarily. They felt that high scoring schizotypes who had experienced a large number of traumatic life events may be vulnerable to experiencing frequent and varied intrusions. This would lead to confusion and an inability to make links between the intrusions and previous trauma. These results had implications for a traumatic cause of psychosis. Symptoms of psychosis that may seem unusual could have their origins in traumatic experiences, but seem removed from reality because of

the manner in which intrusions occur for the client. This work has been developed further by Steel, Fowler and Holmes (2005) where the contextual integration that occurs during encoding of traumatic experiences is felt to be a key variable in understanding the relationship between traumatic experiences and psychosis. Unfortunately space has not allowed for a review of other models of trauma and psychosis. However, for a psychodynamic conceptualisation of schizophrenia as a defensive reaction to traumatic life events rather than as an illness see Honig (1988).

Suggestions for Future Research

The discussion above has not considered the way that people who have psychosis view themselves and other people. It is possible that Personal Construct Theory (PCT) (Kelly, 1955) may enhance our understanding of how traumatic life events could impact on the way people who have psychosis view themselves. Kelly (1955) noted that the concept of validation is important for our well being. If a person commits himself to anticipating a particular event and it takes place, he experiences validation. If his predictions do not take place, his anticipation is invalidated. PCT models have highlighted the role that invalidation could play in the development of psychosis (e.g. Lorenzini, Sassaroli and Rocchi, 1989). The concept of invalidation has also been used to investigate the construction of self in psychosis by Gara, Rosenberg and Cohen (1987). They felt that having an elaborate self-construct or being able to view oneself in a variety of ways, enables us to cope with challenges to our identity presented by stressful life events. They felt that people may develop schizophrenia because they have an unelaborated self-construct that is unable to bear continuous invalidation. An extension of this work is to examine the invalidating effects of traumatic life events in psychosis and their effect on the construction of self. This will be subject to investigation in the main thesis of this volume.

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Appendix 1: Search strategy for obtaining literature reviews on trauma and psychosis

Appendix 2: Literature review papers identified through PsychInfo searches

Appendix 3: Figures for PsychInfo searches using a variety of terms

Appendix 1: Search strategy for obtaining literature reviews on trauma and psychosis

In order to make the search as wide ranging as possible, the terms 'psychosis' and 'schizophrenia' were used in two separate searches to identify literature on trauma and psychosis. The term 'schizophrenia' was used in the first strategy and the term 'psychosis' was used in the second strategy. The PsychInfo data base was searched in October 2006, using the strategies outlined in tables 1 and 2 below.

Table 1: Search strategy using terms 'schizophrenia' and 'trauma' to obtain relevant articles on the topic of trauma and psychosis

Search Term	Limit Set	Number of references
Schizophrenia	-	64,572
Trauma	-	24,185
Schizophrenia and Trauma	-	364
Schizophrenia and Trauma	English and Human	280
Schizophrenia and Trauma	English, Human, Literature Review, after 1980	18
Schizophrenia and Trauma	English, Human, Prospective Study	1

Table 2: Search strategy using terms 'psychosis' and 'trauma' to obtain relevant articles on the topic of trauma and psychosis

Search Term	Limit Set	Number of references
Psychosis	-	28,647
Trauma	-	24,185
Psychosis and Trauma	-	421
Psychosis and Trauma	English and Human	253
Psychosis and Trauma	English, Human, Literature Review, after 1980	13
Psychosis and Trauma	English, Human, Prospective Study	2

The results were limited to papers after 1980 that were literature reviews in order to provide an initial manageable number of references to review. This resulted in 18 trauma and schizophrenia references and 13 trauma and psychosis references. The full search results are shown in tables 3 and 4 in appendix 2.

Nine of the 31 articles appeared in both tables. Therefore 22 papers were identified and scanned for relevance. Four book chapters and an unpublished thesis were not obtainable. Three papers had used trauma as applied to a brain injury rather than psychological experience and were not relevant to this review. One paper and one book chapter were not relevant to trauma and psychosis. Therefore a final set of 12 literature review articles written after 1980 was used to provide a starting point for the literature on trauma and psychosis.

Appendix 2: Literature review papers identified through PsychInfo searches

Table 3: PsychInfo search results for trauma and psychosis limited to English, Human and Literature Review on 15th October 2006. All results after 1980.

Authors	Title	Source
Thirugnanasampanthan, U. Foster, A. Rauch, R.A	Reversible cerebral atrophy: A case report and literature review.	General Hospital Psychiatry . Vol 28(5) Sep-Oct 2006, 458-462.
van-Os, J. Krabbendam, L. Myin-Germeys, I. Delespaul, P.	The schizophrenia envirome.	Current Opinion in Psychiatry . Vol 18(2) Mar 2005, 141-145.
Read, J. van-Os, J. Morrison, A. P. Ross, C.A.	Childhood trauma, psychosis and schizophrenia: A literature review with theoretical and clinical implications.	Acta Psychiatrica Scandinavica . Vol 112(5) Nov 2005, 330-350.
Kinzie, J.D. Friedman, M.J.	Psychopharmacology for Refugee and Asylum-Seeker Patients.	Wilson, J.P. (Ed) Drozdek, B. (Ed). (2004). Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims. (pp. 580-600). New York, NY, US: Brunner-Routledge.
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Read, J. Ross, C.A.	Psychological trauma and psychosis: Another reason why people diagnosed schizophrenic must be offered psychological therapies.	Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry . Vol 31(1) Mar 2003, 247-268.
Morrison, A.P. Frame, L. Larkin, W.	Relationships between trauma and psychosis: A review and integration	British Journal of Clinical Psychology . Vol 42(4) Nov 2003, 331-353.
Seedat, S.	Linking Posttraumatic	Journal of Nervous

Stein, M.B. Oosthuizen, P.P. Emsley, R.A. Stein, D.J.	Stress Disorder and Psychosis: A Look at Epidemiology, Phenomenology, and Treatment.	and Mental Disease . Vol 191(10) Oct 2003, 675-681.
Pennell-Sloane, P.V.	Psychosocial contextual correlates of schizophrenia: A critical literature review.	Dissertation Abstracts International: Section B: The Sciences and Engineering . Vol 62(1-B) Jul 2001, 560.
Bertolini, M. (Ed) Giannakoulas, A. (Ed) Hernandez, M. (Ed)	Squiggles and spaces revisiting the work of D. W. Winnicott, (Vol. 2).	Squiggles and spaces revisiting the work of D. W. Winnicott (2001). Philadelphia, PA, US: Whurr Publishers.
Goodman, L.A. Rosenberg, S.D. Mueser, K.T. Drake, R.E.	Physical and sexual assault history in women with serious mental illness: Prevalence, correlates, treatment, and future research directions.	Schizophrenia Bulletin . Vol 23(4) 1997, 685-696.
Bebbington, P. Bowen, J. Ramana,R.	Life events and psychotic disorders.	Miller, T.W. (Ed). (1997). Clinical disorders and stressful life events. (pp. 89-119). Madison, CT, US: International Universities Press, Inc
Deering, C.G. Glover, S.G. Ready, D. Eddleman,H.C. Alarcon, R.D.	Unique patterns of comorbidity in posttraumatic stress disorder from different sources of trauma.	Comprehensive Psychiatry . Vol 37(5) Sep-Oct 1996, 336-346.

Table 4: Trauma and schizophrenia limited to English, Human and Literature Review on 15th October 2006. All results listed after 1980.

Author	Title	Source
Thirugnanasampanthan, U. Foster, A. Rauch, R.A.	Reversible cerebral atrophy: A case report and literature review.	General Hospital Psychiatry . Vol 28(5) Sep-Oct 2006, 458-462.
van-Os, J. Krabbendam, L. Myin-Germeys, I. Delespaul, P.	The schizophrenia envirome.	Current Opinion in Psychiatry . Vol 18(2) Mar 2005, 141-145.
Baigent, M.F.	Understanding alcohol misuse and comorbid psychiatric disorders.	Current Opinion in Psychiatry . Vol 18(3) May 2005, 223-228.
Lysaker, P.H. Whitney, K.A.	Clinical and Psychosocial Correlates of Anxiety Related Symptoms in Schizophrenia.	Velotis, C.M. (Ed). (2005). Anxiety disorder research. (pp. 1-19). Hauppauge, NY, US: Nova Science Publishers.
Read, J. van-Os, J. Morrison, A.P. Ross, C.A.	Childhood trauma, psychosis and schizophrenia: A literature review with theoretical and clinical implications.	Acta Psychiatrica Scandinavica . Vol 112(5) Nov 2005, 330-350.
Kinzie, J.D. Friedman, M.J.	Psychopharmacology for Refugee and Asylum-Seeker Patients.	Wilson, J.P. (Ed); Drozdek, B. (Ed). (2004). Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims.
Bunney, B.G. Bunney, W.E. Stein, R. Potkin, S.G.	Cortical pathology in schizophrenia: A review of data from the dorsolateral prefrontal cortex.	Current Opinion in Psychiatry . Vol 16(Suppl2) Apr 2003, S9-S14.
Read, J. Ross, C.A.	Psychological trauma and psychosis: Another reason why people diagnosed schizophrenic must be	Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry . Vol 31(1) Mar 2003, 247-

	offered psychological therapies.	268.
Seedat, S. Stein, M.B. Oosthuizen, P.P. Emsley, R.A. Stein, D.J.	Linking Posttraumatic Stress Disorder and Psychosis: A Look at Epidemiology, Phenomenology, and Treatment.	Journal of Nervous and Mental Disease . Vol 191(10) Oct 2003, 675-681.
Pennell-Sloane, P.V.	Psychosocial contextual correlates of schizophrenia: A critical literature review.	Dissertation Abstracts International: Section B: The Sciences and Engineering . Vol 62(1-B) Jul 2001, 560.
Sweeney, J.A. Haas, G. Nimgaonkar, V.	Schizophrenia: Etiology.	Hersen, M. (Ed); Bellack, A.S. (Ed). (2000). Psychopathology in adulthood (2nd ed.). (pp. 278-304). Needham Heights, MA, US: Allyn & Bacon.
Taylor, E.	Early disorders and later schizophrenia: A developmental neuropsychiatric perspective.	Ron, M.A. (Ed); David, A.S. (Ed). (1998). Disorders of brain and mind. (pp. 255-279). New York, NY, US: Cambridge University Press.
de-Silva, P.	Cultural aspects of post-traumatic stress disorder.	Yule, W. (Ed). (1999). Post-traumatic stress disorders: Concepts and therapy. (pp. 116-138). New York, NY, US: John Wiley & Sons Ltd.
Edelstyn, N.M.J. Oyebode, F.	A review of the phenomenology and cognitive neuropsychological origins of the Capgras syndrome.	International Journal of Geriatric Psychiatry . Vol 14(1) Jan 1999, 48-59.
Range, L.M. MacIntyre, D.I. Rutherford, D. Billie, S.	Suicide in special populations and circumstances: A review.	Aggression and Violent Behavior . Vol 2(1) Spr 1997, 53-63.

Payne, B. Knott, E. Brown, M. Foster, C.L.		
Goodman, L.A. Rosenberg, S.D. Mueser, K.T. Drake, R.E.	Physical and sexual assault history in women with serious mental illness: Prevalence, correlates, treatment, and future research directions.	Schizophrenia Bulletin . Vol 23(4) 1997, 685-696.
Bebbington, P. Bowen, J. Ramana, R.	Life events and psychotic disorders.	Miller, T. W. (Ed). (1997). Clinical disorders and stressful life events. (pp. 89-119). Madison, CT, US: International Universities Press, Inc.
Olney, J.W.	Excitotoxic amino acids and neuropsychiatric disorders.	Annual Review of Pharmacology and Toxicology . Vol 30 1990, 47-71.

Appendix 3: Figures for PsychInfo searches using a variety of terms

Table 5: Results for literature searches using PsychInfo conducted on 15th October 2006

Search Term	Limit Set	Number of References
Depression		112, 776
Schizophrenia		64,617
Psychosis		28,647
Trauma		24,185
Schizoaffective		3,656
Trauma and depression		2,272
Trauma and schizophrenia		364
Trauma and psychosis		421
Trauma and schizoaffective		22
Trauma and depression	English and Human	2053
Trauma and schizophrenia	English and Human	280
Trauma and psychosis	English and Human	253
Trauma and schizoaffective	English and Human	21
Trauma and depression	English, Human, Literature Review	81
Trauma and schizophrenia	English, Human, Literature Review	20
Trauma and psychosis	English, Human Literature Review	15
Trauma and schizoaffective	English, Human, Literature Review	0
Trauma and psychosis	English, Human, Prospective Study	2
Trauma and schizophrenia	English, Human, Prospective Study	1
(Trauma and psychosis) and (thought and disorder)		10